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# The JOURNAL

OF THE INDIANA STATE  
MEDICAL ASSOCIATION

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ANNUAL  
MEETING

October  
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W. P. Loh, M.D.

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The negative power of undue anxiety  
in congestive heart failure...

This man thinks he can no longer  
take breathing for granted.



Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

#### *Aid in rehabilitation*

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

#### *Concomitant use with primary agents*

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

The positive power of

**Libritabs®**  
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5-mg, 10-mg, 25-mg tablets

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up to 100 mg daily

for severe anxiety  
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

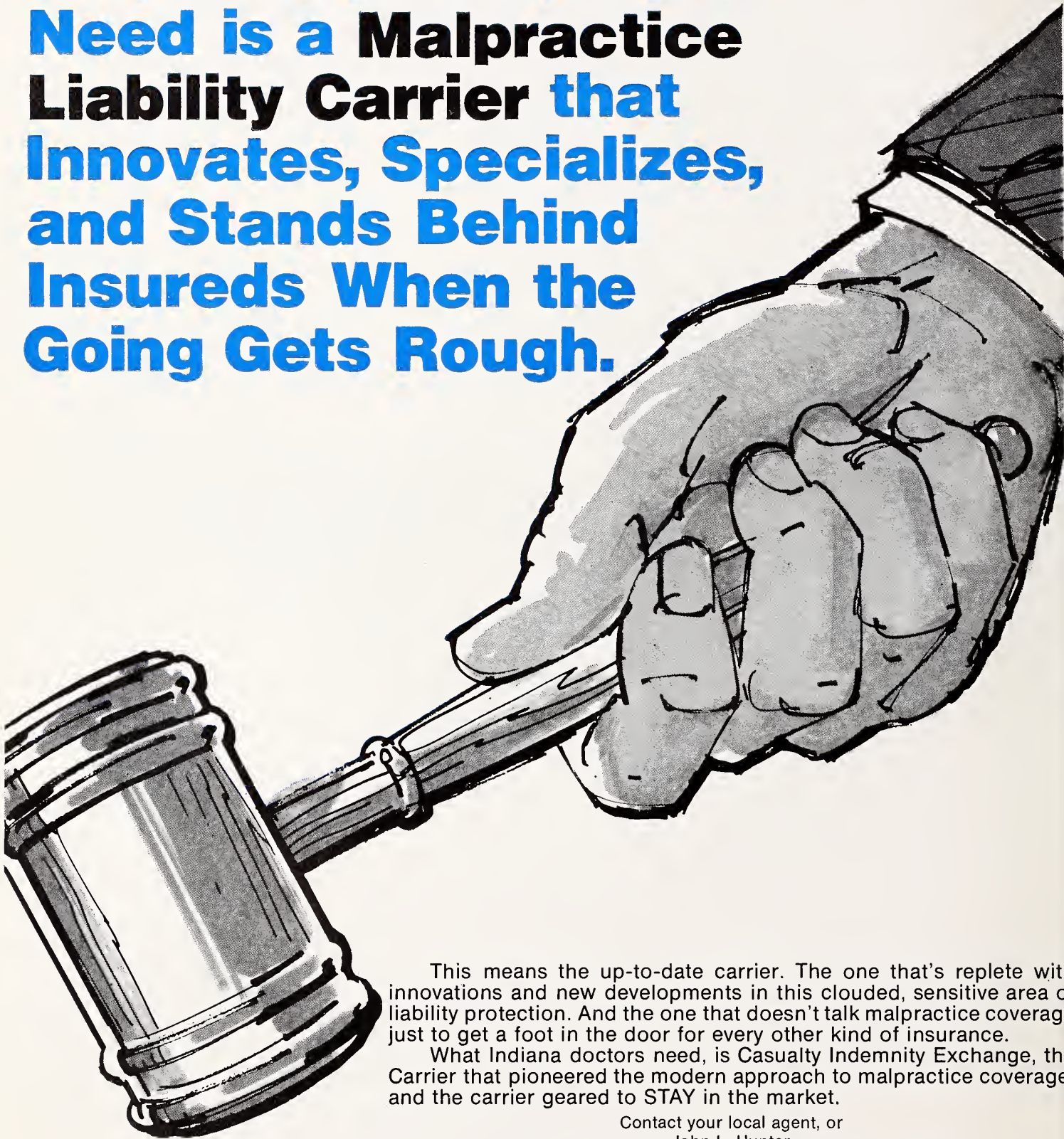
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EDITORIAL AND  
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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on a glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Romsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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About Our Cover  
on page 756

# Why send him to the islets of Langerhans?



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determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin. **Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B)98-146-103-C

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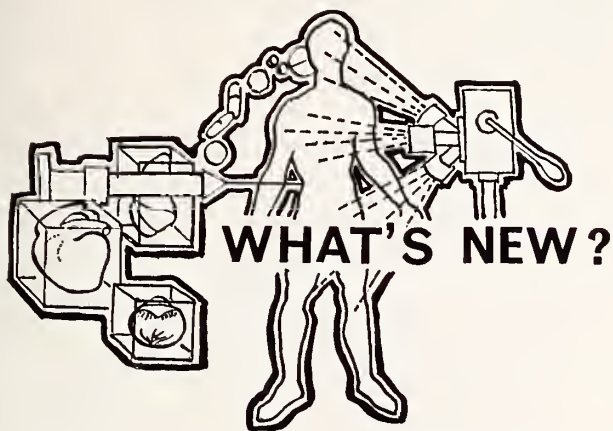
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\* \* \*

International Therapeutics announces a mechanical percussor for the creation of percussion waves across the lung. The device is used to free deposits of mucoid material in bronchi afflicted with emphysema, cystic fibrosis or chronic bronchitis. It is light in weight and is suitable for home use.

\* \* \*

Harcourt Brace Jovanovich has published a new book "Hypnosis: Is It For You?" Written by Lewis R. Wolberg, M.D., a pioneer in the use of hypnosis, the book lists and discusses the proper uses and limitations of hypnosis. Dr. Wolberg is Clinical Professor of Psychiatry at New York University Medical School.

\* \* \*

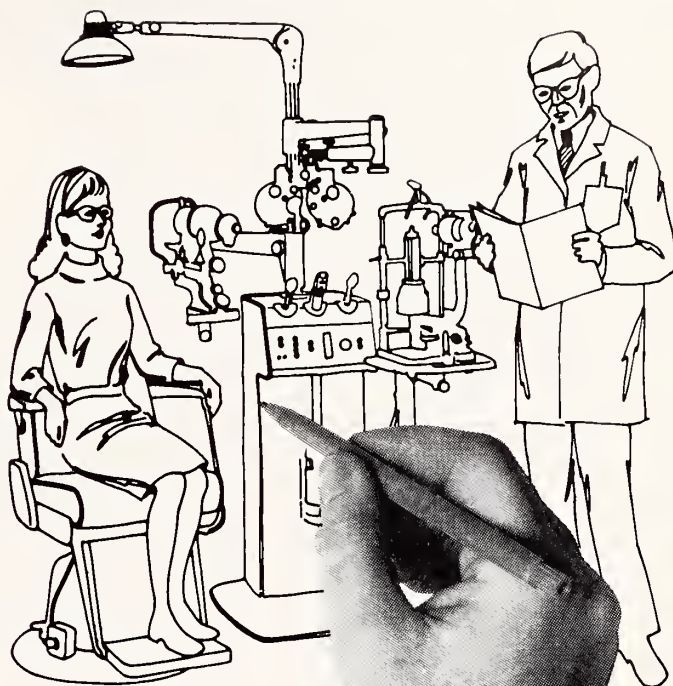
The USV Pharmaceutical Corporation has published seven ethnic diets suitable for diabetics. These include Mexican-American, Puerto Rican, Italian-American, Jewish, Chinese, Southern American and American. Each diet is made up with a food exchange list, daily food requirements and a sample menu. USV will supply copies of the diets to physicians on request.

\* \* \*

Motorola has developed a two-way radio system which transmits an electrocardiograph signal to the hospital for interpretation and then returns therapeutic advice for use during the patient's trip to the hospital. Most early deaths from cardiac infarction are due to disturbances of rhythm. Many of them may be avoided with proper early treatment. The Motorola device is the one described by Doctors Anderson, Knoebel and Fisch of the Krannert Institute of Cardiology.

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News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



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7.	John M. Records, Franklin .....	Merrill M. Weseman, Franklin .....	June 14, 1972, Greenwood
8.	David Dietz, Muncie .....	Arthur Jay, Muncie .....	June 7, 1973, Muncie
9.	Don W. Boyer, Lebanon .....	Clarence G. Kern, Lebanon .....	June 28, 1972, Lebanon
10.	Lambro Dimitroff, Hammond .....	Mario D. Mansueto, Munster .....	May 30, 1973, Hebron
11.	John Elleman, Kokomo .....	Fred Poehler, La Fontaine .....	Sept. 20, 1972, Kokomo
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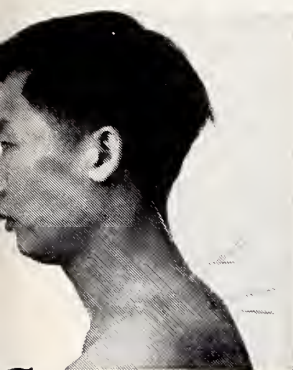
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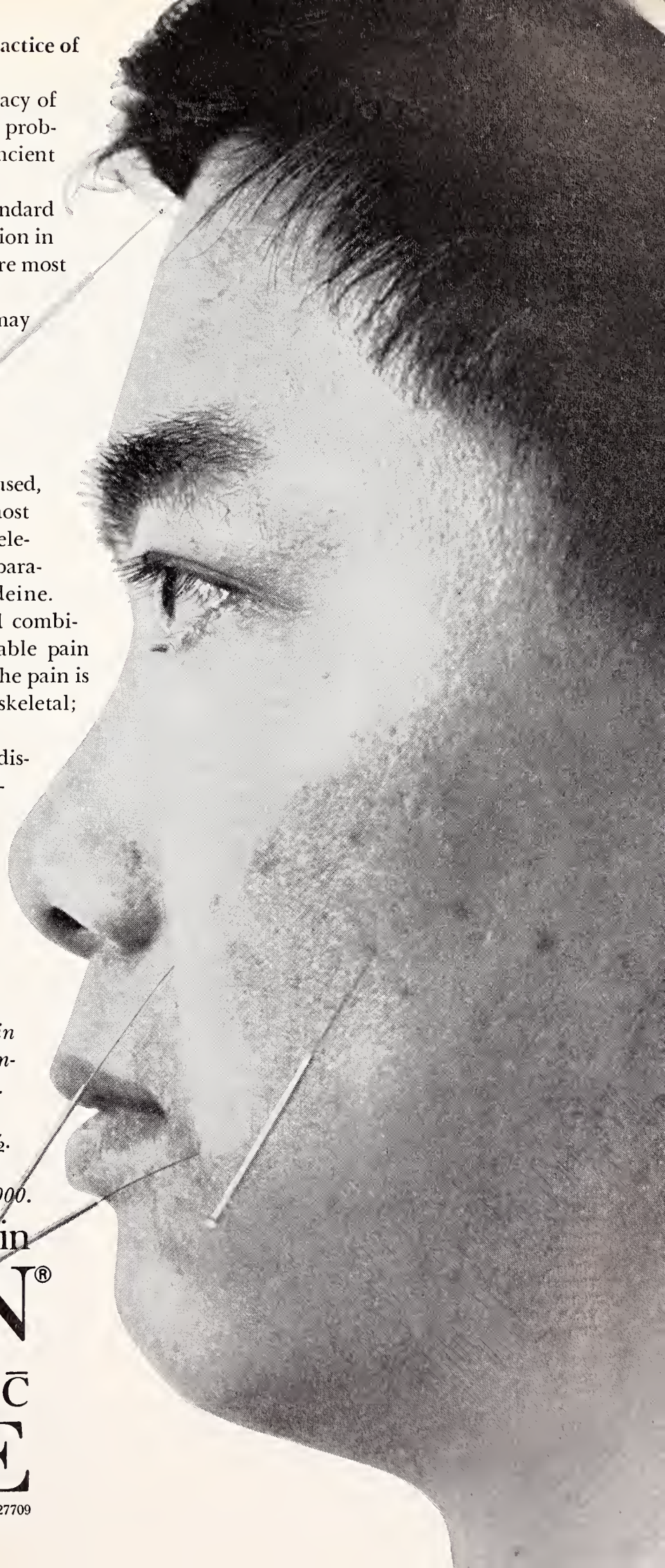
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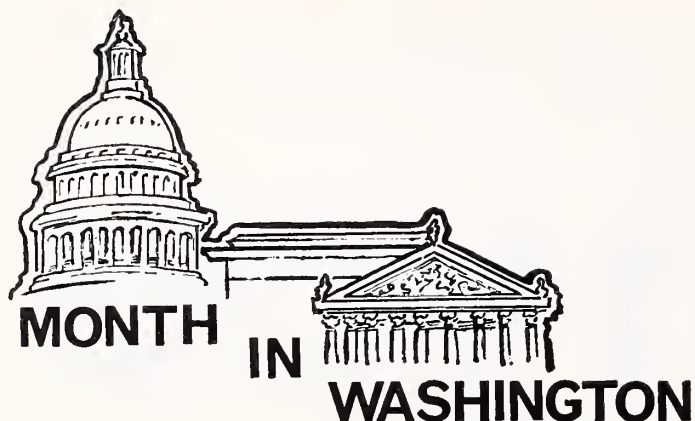
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to have  
and hold onto**







This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the first of each month preceding month of issue.

THE AMERICAN Medical Association has asked Congress to beef up the Administration's budget for medical education and other health programs.

"WE BELIEVE that, instead of terminating the federal construction program for medical schools at the end of fiscal year 1973, as has been proposed by the Administration, at least \$200 million per year, beginning immediately and continuing for at least three years, is going to be necessary," said Raymond T. Holden, M.D., a member of the AMA's Board of Trustees, before a subcommittee of the House Appropriations Committee.

DR. HOLDEN, accompanied by C. H. William Ruhe, M.D., Director of the AMA Division of Medical Education, told the Subcommittee "We have received information from a number of medical schools that their plans, developed over the past years, are absolutely dependent on a federal construction grant program."

PRESENT LEVELS of funding, the AMA spokesman said, "will leave several of these schools in the position of having made the commitment (for increased enrollment) in good faith and implemented the first phase (basic facilities), only to find the federal program of assistance may not continue" for the implied commitment of federal help for construction of clinical facilities.

"MOREOVER, SOME NEW medical schools are completely dependent on federal funds for construction in order to get started," said Dr. Holden. "Even if they can find a way to go ahead without federal aid for construction, these schools reach full operation much more slowly without federal funds."

"THE ADMINISTRATION'S proposal for guaranteed loans and interest subsidies to spur construction is not a feasible method of assuring construction," Dr. Holden said. With many private medical schools living a hand-to-mouth existence, it is not realistic to expect them to amortize the costs of facilities producing no income, he declared.

NOTING that the Administration has requested \$5 million for support of family practice training next fiscal year while the legislation authorizes \$35 million, Dr. Holden said, "We would support full funding if there were assurances that the funds could be used at this time." One of the more serious shortages in the profession is for family practitioners. He proposed that \$20 million be provided until more programs are geared up.

Continued on page 733.





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As an active, involved member, you can influence policy by making your views known to your delegates, both national and state. It is your democratic right — and responsibility.

Write your delegates, call them, see them. If they aren't responsive, tell them they'll be hearing from you at election time.

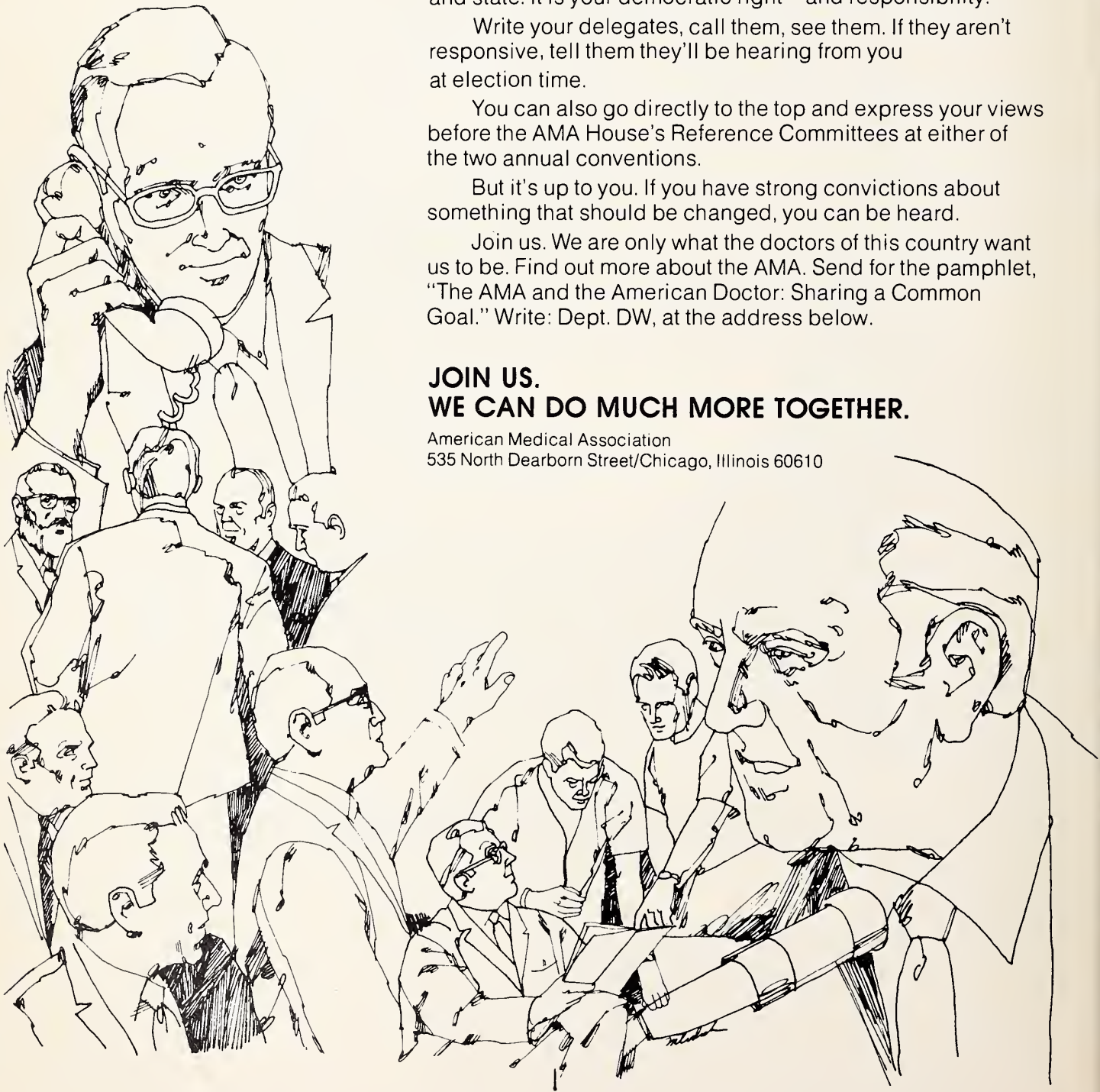
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

Join us. We are only what the doctors of this country want us to be. Find out more about the AMA. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

## **JOIN US. WE CAN DO MUCH MORE TOGETHER.**

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MUCH MORE MONEY is needed for programs to combat alcoholism, Dr. Holden testified. The Administration's 1972 budget "does no more than mark time in both research and training, particularly in view of increasing costs. There is need for full appropriation of the \$80 million authorized for grants to states for treatment and rehabilitation programs.

THE ADMINISTRATION'S PLAN to cut \$15 million from manpower development programs of the National Institute of Mental Health was criticized, particularly the slash in funds for the psychiatric residency program as "the first step in a complete abolition of that program." The residency program is needed to cope with the rising incidence of mental illness and because training funds have not been forthcoming from other sources, he said.

THE APPROPRIATIONS Committee was urged to limit the use of funds for health maintenance organizations to a completion and evaluation of the 110 grant projects already authorized by law and to "preclude any further expansion without congressional direction."

"THE SCOPE OF HEW'S present activity is more than ample to establish an experimental basis to ascertain any validity in this form of contract practice for future governmental support," Dr. Holden told the lawmakers.

#### PHYSICIAN PANEL DISCUSSES HMOs

HEALTH MAINTENANCE Organizations were the subject of a panel discussion at the annual meeting of the U.S. Chamber of Commerce in Washington.

JEAN HARRIS, M.D., of the National Medical Foundation, questioned whether HMOs are capable of coping with health problems in the inner city. The particular problems of these areas make it "almost impossible" for an HMO as we understand them today to function. The costs will be high and the poor will not agree to pay monthly premiums. "The only solution would be for the government to pay the enrollment cost," he said.

CLINTON MCGILL, M.D., the AMA representative on the panel, said savings in HMOs come from under-utilization, not health maintenance, which he described as "an unfortunate term." Dr. McGill said Kaiser Permanente has been confined to relatively low-risk groups. "Prepaid practice is not an acceptable form of delivery to many people, although it is a legitimate experiment," he told the audience. "Even Kaiser officials have urged a go-slow approach and questioned whether universal enrollment is possible or financially feasible," Dr. McGill noted. "The position of the AMA," he said, "is to study the system and find what it can do and build on its strengths."

GEORGE WHEATLEY, M.D., medical director for Metropolitan Life, noted that Paul Ellwood, M.D., a developer of the HMO concept, has said that businesses interested in HMOs must be prepared to wait five years for a return on a \$10 million investment



and to withstand the publicity from possible shoddy public service. Dr. Wheatley questioned whether any of the HMO bills offered sufficient incentives for physicians to participate in HMOs.

JOHN VENEMAN, Undersecretary of HEW, denied that HMOs would be a stepping-stone to socialized medicine. He predicted some 40 million people might be covered by 1980. Concern about socialized medicine should be directed at legislation such as the Kennedy bill rather than HMOs, he said in reply to a question. DR. EDWARD ANNIS, moderator, said statistics demonstrate that the chief health problems of this country stem from life style—alcoholism, obesity, accidents, etc.—rather than health care. He asked how changing the system will improve this.

#### FOUNDATIONS URGED BY AAFMC SPOKESMAN

MEDICAL care foundations can be set up "at an incomparably lower cost" than closed-panel prepaid group practice and "with maximum acceptance by the medical profession," the American Association of Foundations for Medical Care told Congress.

URGING THAT HMO legislation specifically embrace foundations, F. William Dowda, M.D., president of the Georgia Foundation for Medical Care, said, "government should encourage active competition between the major modalities of medical care in every geographical area—stimulating efficiency—and permitting comparison between systems."

TESTIFYING BEFORE the House Subcommittee on Health, Dr. Dowda said "the Foundation for Medical Care is the most far-reaching, realistic effort that American medicine has made during the past 30 years to meet the needs of the people for better systems of medical care delivery.

"FOUNDATIONS are soundly conservative in that they build solidly on the community's existing health care facilities and they seek to improve rather than to displace the worthy characteristics and potentialities of our traditional medical ways," Dr. Dowda said.

DR. DOWDA ARGUED that foundations have shown they can make individual practice competitive with group practice. "Congress has an opportunity, by simultaneously encouraging the development of group practice and individual practice foundation programs, to give people a choice between equally desirable alternative health service plans."

#### 288 HEALTH PROFESSIONALS ASSIGNED TO MEDICALLY NEEDY AREAS

THE ADMINISTRATION witnesses expressed doubt that one of the principal bills before the subcommittee—introduced by Rep. William Roy, M.D., Kansas Democrat—would cover foundations and urged that it be amended to include foundations, as does its own bill. Dr. Roy and other subcommittee members indicated they would make the change.

THE HMO BILL introduced by Sen. Edward Kennedy (D., Mass.) flatly

excludes foundations except perhaps in rural areas.  
THE NATIONAL HEALTH Service Corps has made its first mass assignment of medical personnel to areas short of health services. The program represents the first federal provision of direct care to the medically needy except for special cases such as Indians.

THIS SUMMER the program will send 152 HEW physicians, 20 dentists, 72 nurses and 44 other health professionals to some 122 communities, both urban and rural.

THE SALARIES of the health professionals will be paid by the federal government. The young physicians—many fulfilling draft obligations—will draw between \$12,000 and \$15,000 per year. The patients will be charged fees on the basis of their ability to pay. Funds collected may be retained to provide additional care within the community, or returned to the federal government.

ESTABLISHED under a law signed by President Nixon 17 months ago, the new organization will be headed by H. McDonald Rimple, M.D., who had been serving as acting director.

#### DBS, FDA, HEW TRANSFERS TALKED

HEW SECRETARY Elliot L. Richardson already engaged in a fight with Congress over whether the Food and Drug Administration will remain in the Department of Health, Education, and Welfare, ordered transfer of the Division of Biologics Standards to the FDA.

RICHARDSON SAID the transfer would result in an "obvious advantage" through consolidation of the similar activities of the two agencies. He said there was no implied criticism of past performances of DBS. The transfer was effective July 1.

CONCERNING legislation that would take FDA out of HEW and make it the base of a new and independent consumer safety agency, Richardson said it would sell the consumer a phony bill of goods . . . deal the cause of consumer safety a crushing setback . . . abandon the field to exploiters of the consumer by destroying existing mechanisms for regulation."

HE SAID IT WAS "to my complete disbelief" that the Senate Commerce Committee voted 17 to 1 for the independent FDA-consumer safety legislation which runs counter to the Nixon Administration's executive branch reorganization proposal for fewer rather than more government departments and agencies.

FDA, which has been charged with laxness by some Congressmen, was criticized by a group of leading scientists as being too strict. In a letter to the House Commerce Subcommittee on Health, they said:

"WE BELIEVE a change in the drug regulatory system is badly needed. The system too often stifles creativity and escalates costs of research, perpetuates a continuing decline in the number of new drugs entering the market in this country, and may be depriving the practicing physician of agents beneficial to patient care."

IN ORDERING DBS transferred to FDA, Richardson said:



"DURING the past decade there have been repeated examinations of the question of the best organizational locus for the regulatory function of the Division of Biologics Standards. "ON THE ONE HAND there is important advantage in having a close working relationship between research scientists and the administrators charged with enforcing federal regulations related to biologic materials. On the other hand, there is the obvious advantage gained by consolidating the DBS regulatory function with similar activities carried out on a much broader range by the Food and Drug Administration.

"WE HAVE DECIDED that it is timely to bring about a consolidation, and to do so in such a way as to maintain the advantages of close scientific collaboration that have well served the DBS.

"SEVERAL WEEKS ago I announced my decision to consolidate certain functions of the DBS with the Food and Drug Administration. Following that announcement the Director of the National Institutes of Health provided his analysis of the DBS operations and the change in organization to Dr. Merlin K. Duval, Assistant Secretary for Health and Scientific Affairs. Dr. Duval and Dr. Marston have recommended that the consolidation can best be implemented by continuing to maintain as a functioning unit the regulatory activity with the research that is related to regulation. . . ."

THE AMERICAN Medical Association sided with Richardson in opposing the proposed removal of FDA from HEW. An AMA statement to Congress said:

"THE AMERICAN MEDICAL Association does not believe that the proposed transfer of drug evaluation and regulation represents a sound course of action. We would urge your committee to reject any proposal which would isolate the testing, evaluation and regulation of drugs from the department of government bearing the principal responsibility for the health of our people. . . ."

"WE ARE concerned that in any agency oriented primarily toward consumer and product safety the therapeutic benefits resulting from risk-bearing drugs may not be given appropriate recognition. Pharmaceuticals are unique and should not be described as 'consumer products' within the common understanding of that term. . . ."

"THE RISKS OF administration for therapeutic purposes must always be balanced with the need, a judgment to be made by the physician. The entire process of developing, evaluating, and prescribing of medication is a continuing exercise in experienced professional judgment. In our opinion, the greater safety factor can be gained by retention of drug regulation within this professional and health oriented environment."

#### AMA SUPPORTS EXPANDED NHLI RESEARCH PROGRAM

THE AMERICAN Medical Association supported—with modifications—legislation that would expand the National Heart and Lung Institute's attack upon diseases of the heart and

blood vessels, the lungs and blood.

IN A STATEMENT SENT to the House Health Subcommittee, Dr. Ernest B. Howard, AMA executive vice president said:

"THESE DISEASES are in the forefront in terms of the devastating effect they have upon the lives and well-being of our people. An intensified and augmented national effort for research concerning these diseases is highly desirable so that we may increase our ability to provide preventive, therapeutic and rehabilitative measures for our patients. Thus, we support an expanded national research program, such as proposed in H.R. 13715, and in doing so, we shall offer recommendations for modification to the bill."

THE AMA recommended that the number of new research centers under the program be limited to a maximum of 30 and that patient care and demonstrations in the centers be barred "unless tied in and required for research."

"WE ALSO CALL TO YOUR attention some overlap in this legislation with Regional Medical Programs," Dr. Howard said. "While research is basic to NIH, general aspects of education, training and demonstrations for heart disease, etc., are properly within RMP. Thus, while the development of new basic research information can be expected within the NIH, the dissemination of information on new techniques to practicing physicians, through various educational means, including demonstrations, is the undertaking of RMP. We believe a clear expression should be made for research in NIH, limiting patient care and demonstration to research needs, and providing for education, training and demonstrations through RMP. In preservation of the value and integrity of both programs, we urge the deletion of sections 413 (a) (4) and (7) of H.R. 13715 providing for programs and centers for studies, large scale testing and evaluation and demonstrations, as well as for professional training relating to all aspects of cardiovascular, pulmonary and blood diseases."

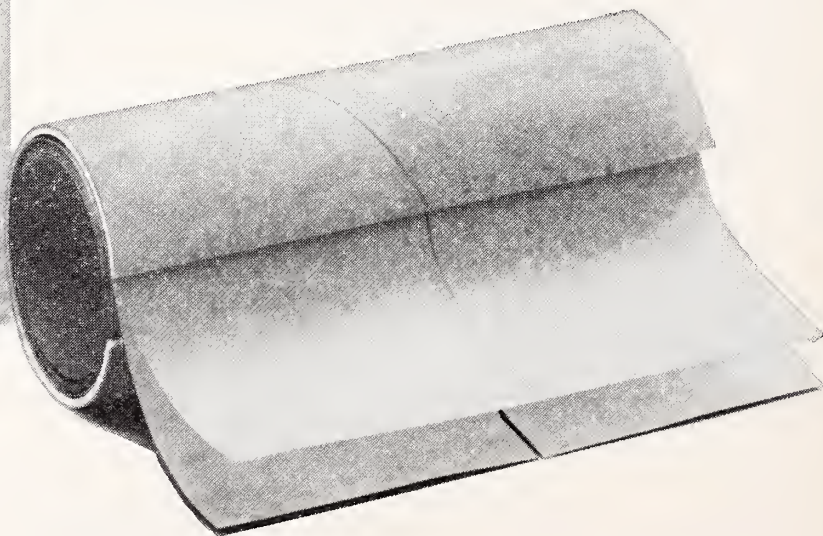
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## Severe Head Injuries: A Retrospective Review of 100 Consecutive Cases Marion County General Hospital\*

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IN the United States, head injury ranks as the number one cause of death from accidents of all types in the 1 to 44 year age group.<sup>1</sup> One person in 200 will require care for injury to the head each year.<sup>1</sup> Three million persons each year suffer head injuries from traffic accidents alone.<sup>1</sup> Five percent of these are fatal.<sup>1</sup>

This paper presents an analysis of 100 consecutive patients admitted

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to the Marion County General Hospital during the period from 1965 to 1969 with one or more of the following final diagnoses: (1) subdural hematoma, (2) subdural hygroma, (3) epidural hematoma, (4) intracerebral hematoma.

From the data compiled, supplemented with material published by other authors, a discussion is presented regarding the characteristics, diagnosis, management and prognosis of the head-injured patient.

### Survey of Lesions

#### *Acute Subdural Hematomas* (0-3 days)

Acute subdural hematoma was the most common lesion (58 patients). These patients tended to be white (40 patients) males (47 patients) in the 40 to 60 age group and most received their injury in traffic accidents (18 automobile, 6 motorcycle, and 5 pedestrian injuries), falls (15) or assaults (9).

The most consistent physical find-

ing in these patients was coma. Pupillary dilatation and contralateral hemiparesis were also frequently encountered while less common findings included seizures and dysphasia. Serious injury to the abdomen, head and neck, thorax, and/or extremities was present in 12% of our patients.

Plain skull films revealed fractures in 19 cases. Of the 37 patients studied angiographically, 70% demonstrated a shift of the midline.

Forty-two patients were operated upon within the first 6 hours after injury. The mortality rate for this group was 74%. Of the 16 patients not operated on within six hours, 8 died (2 of whom died before surgery). The total mortality rate was 67.2%. Only five were discharged without neurologic deficit.

#### *Subacute Subdural Hematomas* (4-21 days)

Nineteen patients suffered subacute subdural hematomas. Their ages were evenly distributed in all age categories except those under 20. The



majority in this category were white females (9).

The majority of these patients (8) were injured in falls rather than in automobile accidents, as was the case with acute subdural hematomas. Seven of the patients were admitted comatose while an equal number were admitted with contralateral hemiparesis. Other findings included pupillary dilatation, papilledema, headaches and dysphasia.

Plain skull x-rays demonstrated only two fractures; however, arteriography was diagnostic in all 14 patients studied.

All of these patients were operated upon between 4 and 21 days following injury and, of 19 patients, 5 died. Nine of 14 survivors were discharged with mild neurologic deficit.

#### *Chronic Subdural Hematomas* (greater than 21 days)

Sixteen patients were operated upon for chronic subdural hematomas. Of patients with this lesion, eight were over 40, five were under 10 years of age, and all but one were injured in falls. Three patients were known alcoholics.

While only two patients were admitted in a comatose condition, over half were either stuporous or drowsy upon admission. Pupillary dilatation was not a common finding, but hemiparesis, papilledema, headaches and epilepsy each occurred in approximately 25% of these patients. In no case did plain skull x-rays demonstrate a skull fracture. Again, carotid angiography was diagnostic in all 11 of those in whom it was done.

Nearly all of these patients were operated upon more than 48 hours after admission. There were no deaths. Half of the patients left the hospital without neurologic deficit. Three were known alcoholics.

#### *Subdural Hygromas*

Most of the nine patients with subdural hygroma were alcoholics in their mid 60s who received their injury in a fall. The presenting signs

and symptoms in this group were generally similar to those with subdural hematoma.

Plain skull x-rays demonstrated fractures in two of these patients, and carotid angiography was diagnostic in six of the nine cases. One third of these patients survived, but all had some form of neurologic deficit at the time of discharge.

#### *Epidural Hematomas*

Three of the four patients with epidural hematoma were white males. Ipsilateral pupillary dilatation and contralateral hemiparesis, as well as coma, were among the signs found in these patients. Fracture of the temporal bone was demonstrated in all patients. Two patients had an associated subdural hematoma and died despite surgical evacuation of both the subdural and epidural hematoma. The patients without associated lesions were discharged without neurologic deficit.

#### *Intracerebral Hematomas*

Fifteen patients were found to have intracerebral hematoma, but of these, the majority had an associated intracranial lesion, most frequently acute subdural hematoma.

Each age group over 20 included an equal number of patients. Most of these patients were white, and one third (6) were injured in traffic mishaps, while falls (3) and assaults (3), including gunshot wounds (2) to the head, caused the remainder.

Eight patients were admitted comatose, and six were hemiparetic. Three patients had evidence of a fracture on plain skull x-rays; however, 12 of these 14 patients had an angiographic shift. All patients, except one who died immediately, underwent surgery. Those with associated acute subdural hematomas were operated upon within 6 to 12 hours after injury. The mortality rate was 60% in patients with an intracerebral clot; however, two thirds of those who died had an associated acute subdural hematoma. Both pa-

tients who suffered gunshot wounds to the head died. Of those discharged, two were able to return to their former employment; three had a mild neurologic deficit although they were able to care for themselves; and one patient was discharged totally disabled secondary to visual disturbances.

#### *Combination Intracranial Lesions*

Nineteen patients suffered a combination of two intracranial lesions. The age group, sex and mode of injury were nearly the same as those associated with the acute subdural group. The mortality was 68.5%.

Of the 58 patients with acute subdural hematoma, 15 (26%) had an associated intracranial lesion of which nine were intracerebral blood clots. Three had subdural hygromas, two had chronic subdural hematomas, and one had an epidural hematoma.

Of the 19 patients with subacute subdural hematomas, 3 had an associated lesion (15.8%), and of the 16 patients with a chronic subdural hematoma, 2 also had an acute subdural hematoma. Ten of the 15 patients with intracerebral hematomas also had another intracranial lesion, nine of which were acute subdural hematomas. Seven of nine patients with subdural hygromas had the additional diagnosis of acute, subacute, or chronic subdural hematoma. Only four patients had epidural hematomas, but of these, one had an acute, and one a subacute subdural hematoma.

### **Discussion**

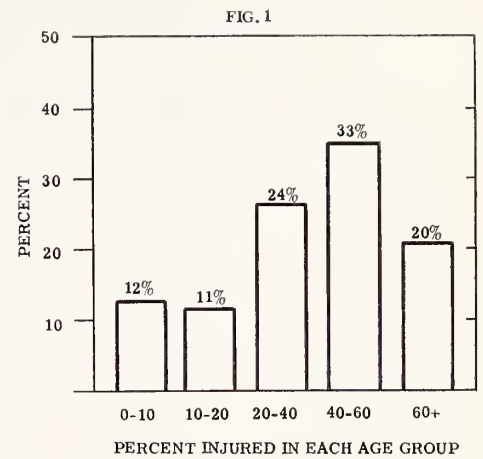
#### *Age, Sex, Race Distribution*

The most common age group involved in the entire series was the 40 to 60 year old category, followed closely by the 60-plus and the 20 to 40 age groups (See Table I). This is consistent with the experience of Freytag, who analyzed 1,367 cases.<sup>2</sup> Males were involved more than twice as often as females (70% vs 30%). Seventy patients were white, and 30 were Negro. This roughly approxi-

Table 1  
AGE DISTRIBUTION

Age	Subdural				Extra- dural	Intra- cerebral	Total
	Acute	Subacute	Chronic	Hygroma			
0-10	3	1	5	0	2	0	11
10-20	9	2	1	1	1	2	16
20-40	15	6	2	1	0	5	26
40-60	19	5	5	1	0	4	34
60+	9	5	3	6	1	4	28

Note: Some patients are counted in more than one diagnostic category due to 19 cases with multiple diagnoses.



mates the population balance in the Marion County area. (Also see Figure 1.)

### Etiology

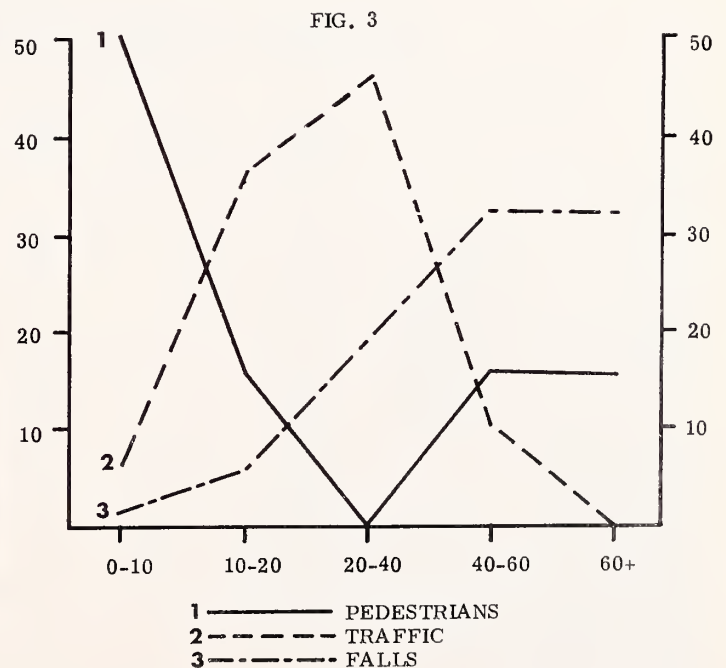
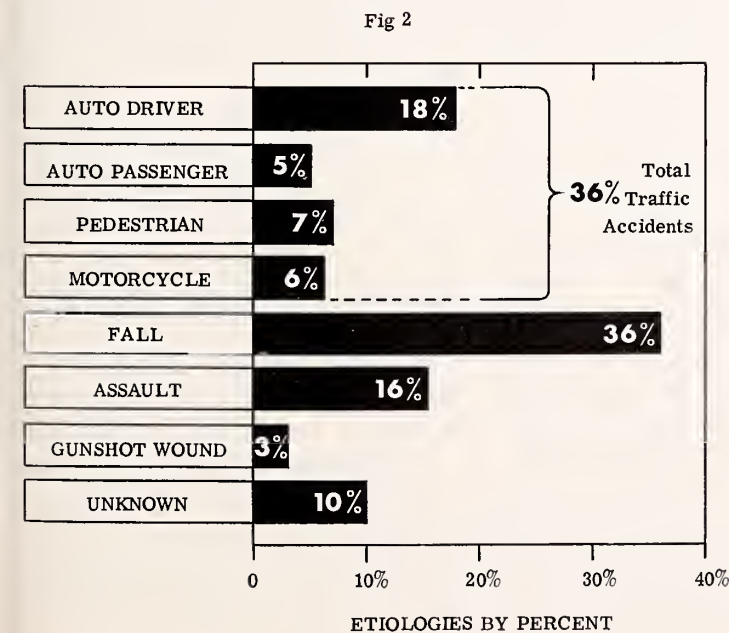
As one can see in Figure 2, falls accounted for the largest number of injuries. In 10 cases, the etiology was unknown. Falls and pedestrian injuries occurred more often in the extremes of age, while head injuries

secondary to automobile or motorcycle accidents involved primarily young adults (Figure 3). Alcohol consumption was believed to have been involved in 23% of these head injuries, of which 5 were automobile accidents, 5 were assaults, and 13 were falls.

### Physical Findings

Coma was characterized by a lack

of purposeful movement in response to pain. Coma was present in 57% of the patients in this series and was the most common physical finding. Of the remaining patients, 27% were stuporous and 16% were admitted in a drowsy condition. Table II illustrates the number of patients in each diagnostic group who were comatose. Table III shows the findings of



ETIOLOGY DISTRIBUTION IN EACH AGE DIVISION IS SHOWN AS PERCENTAGE OF TOTAL NUMBER IN EACH ETIOLOGIC GROUP.



Table II  
INCIDENCE OF COMA

	Total Patients	Number Comatose	Percent Comatose
Acute SDH	58	44	76%
Subacute SDH	19	7	36.9%
Chronic SDH	16	2	12.5%
Subdural Hygroma	9	6	66.6%
Extradural Hematoma	4	1	25%
Intracerebral Hematoma	15	8	53.4%

other investigators for comparison.<sup>3,4</sup>

Forty-five percent of the patients had some degree of hemiparesis on initial physical examination. This was contralateral to the site of the hematoma in 25 cases, and ipsilateral in 11 cases. In 9 cases, the site involved was not indicated.

Thirty-four patients had ipsilateral pupillary dilatation, while 12 patients demonstrated contralateral pupillary dilatation. A majority of these patients had acute subdural hematoma. Table IV represents a

breakdown of the physical findings in each diagnostic group. Some of the findings will be listed more than once since some patients had more than one diagnosis.

Hemiparesis and pupillary inequality are generally assumed to indicate the probability of a herniation of the uncus through the tentorial notch with third nerve and brainstem compression. With severe head injury, such compression may lead to decreasing levels of consciousness and finally death. The ulti-

Table III  
PERCENT OF PATIENTS PRESENTING COMATOSE IN OTHER SERIES

	Total No. Cases	Percent Comatose
Munro & Maltby 1941 <sup>(14)</sup>	44	71%
Hooper 1959 <sup>(11)</sup>	83	35%
McKissock et al. 1960 <sup>(3)</sup>	125	33.6%
Gallagher et al. 1968 <sup>(10)</sup>	167	70%
Jamieson et al. 1968 <sup>(6)</sup>	167	68.2%

mate prognosis is often determined at the time of impact, regardless of the treatment. This fact is supported by our high mortality rate in spite of rapid treatment. There is, however, the danger of assuming too readily that this is the case and of failing to begin definitive treatment which may result in useful survival. The brain has a remarkable capacity to recover from severe insults, and, especially in children, we have frequently been surprised by dramatic recovery from severe neurologic deficit.

#### Diagnostic Investigation

A skull fracture was demonstrated in 41% of 53 patients in whom plain

Table IV  
TABLE SHOWS FINDINGS IN VARIOUS CATEGORIES OF INJURY

		Acute SDH	Subacute SDH	Chronic SDH	Subdural Hygroma	Extra-dural Hematoma	Intra-cerebral Hematoma	Total*	Occurrence Ranking
Level of consciousness	Coma	44	7	2	6	1	8	68	1
	Stupor	7	6	5	2	1	6	27	4
	Drowsy	4	3	5	1	2	1	16	6
Pupillary Dilatation	Ipsilateral	27	2	1	3	1	—	34	2
	Contralat.	9	—	1	2	—	—	12	8
Hemiparesis	Ipsilateral	7	1	1	—	—	2	11	10
	Contralat.	15	6	4	3	1	5	34	2
Papilledema		2	3	5	—	—	1	11	10
Headache		2	5	4	—	—	1	12	8
Seizure		9	3	4	4	—	—	20	5
Dysphasia		5	6	1	2	—	1	15	7
Facial Nerve Weakness		2	1	2	—	—	2	7	13
Assoc. Serious Injuries		9	—	1	—	—	—	10	12

\* This number may reflect multiple diagnoses in some patients.

skull radiographs were available (Table V). Freytag reported that 70% of 1,367 autopsied patients with severe head injuries were found to have skull fractures.<sup>2</sup> McKissock found that, among patients with subdural hematomas, 53%, 16.7%, and 8.3% in the acute, subacute and chronic categories, respectively, had skull fractures.<sup>3</sup>

In the comatose patients, skull films are especially valuable in identifying fractures in the squamous portion of the temporal bone which may involve laceration of a meningeal artery or vein resulting in epidural hematoma.

All four patients in our series with epidural hematomas were found to have fractures. McKissock, in July of 1960, in his series of 125 epidural hematomas found that only 9% of patients did not have demonstrable fractures on plain skull x-rays.<sup>5</sup> Jamieson, on the other hand, reported approximately one third of patients in all age groups with epidural hematomas did not have fractures on plain skull x-rays.<sup>6</sup> Mealey has emphasized the fact that, in children and young adults, epidural hematomas not infrequently occur in the absence of radiographically demonstrated skull fracture.<sup>7</sup>

Also of importance is the careful scrutiny of the Towne view for a calcified pineal gland which may be shifted.

When available, echoencephalography is a useful tool in determining a third ventricle shift in children and in the 45% of adults over age 20 whose pineal gland is not radiographically demonstrated.

Angiography was carried out on 83 patients. In 63 cases, the angiogram demonstrated an abnormal shift of cerebral vasculature. In recent years, with the development of new and safer techniques and contrast media, angiography has become an invaluable diagnostic aid in the evaluation of head injuries.

Lumbar puncture was performed on 22 patients. The reasons for lumbar puncture in these patients are un-

known. Lumbar puncture should not be performed on patients with acute head injuries unless an infection or precipitating subarachnoid hemorrhage from a vascular abnormality is suspected. It is also helpful in the assessment of comatose patients from whom an adequate history is unobtainable. Spinal fluid pressure readings are not necessarily indicative of intracranial pressure values and transtentorial herniation may be precipitated or aggravated by puncture of the lumbar dural sac, even if only a few cubic centimeters of cerebral spinal fluid are removed through a small-bore needle.

### Treatment

Care of the head-injured patient ideally begins immediately after injury. Institution of first aid and the proper extrication of the patient from the accident scene may be crucial.

This entails adequate training of rescue and ambulance personnel as well as availability and maintenance of necessary equipment and communications systems.

It is necessary that the physician correctly orients his priorities in the evaluation and treatment of the head-injured patient. An adequate airway must not only be obtained, but also maintained from the outset. Pneumothorax must be appropriately managed with a chest tube; sucking chest wounds must be sealed or positive pressure breathing instituted. Hypoxia superimposed on head injury may be a fatal combination.

Table V  
PERCENT SKULL FRACTURES AND ANGIOGRAPHIC SHIFTS BY DIAGNOSTIC GROUPS

	Percent Skull Fractures	Percent Vascular Shift on Angiogram
Acute SDH	36%	70%
Subacute SDH	15.8%	88%
Chronic SDH	0%	73%
Subdural Hygroma	21.2%	66%
Extradural Hematoma	100%	100%
Intracerebral Hematoma	26.7%	82%

Serial blood gas determinations can be extremely helpful in following the patient in this regard.

Tracheostomy may also be necessary. Because of the eminent danger of hypoxia, tracheostomy was performed in 35 of our patients, of whom 28 (80%) eventually died. Twenty-one (75%) of the 28 patients who died with tracheostomies had suffered acute subdural hematomas. Likewise, those patients who required surgery within six hours very often were the same patients who underwent tracheostomy. Twenty-nine of these patients were comatose, while the six remaining patients were stuporous. In this series, 74% of the patients with acute subdural hematoma underwent surgery within six hours of injury.

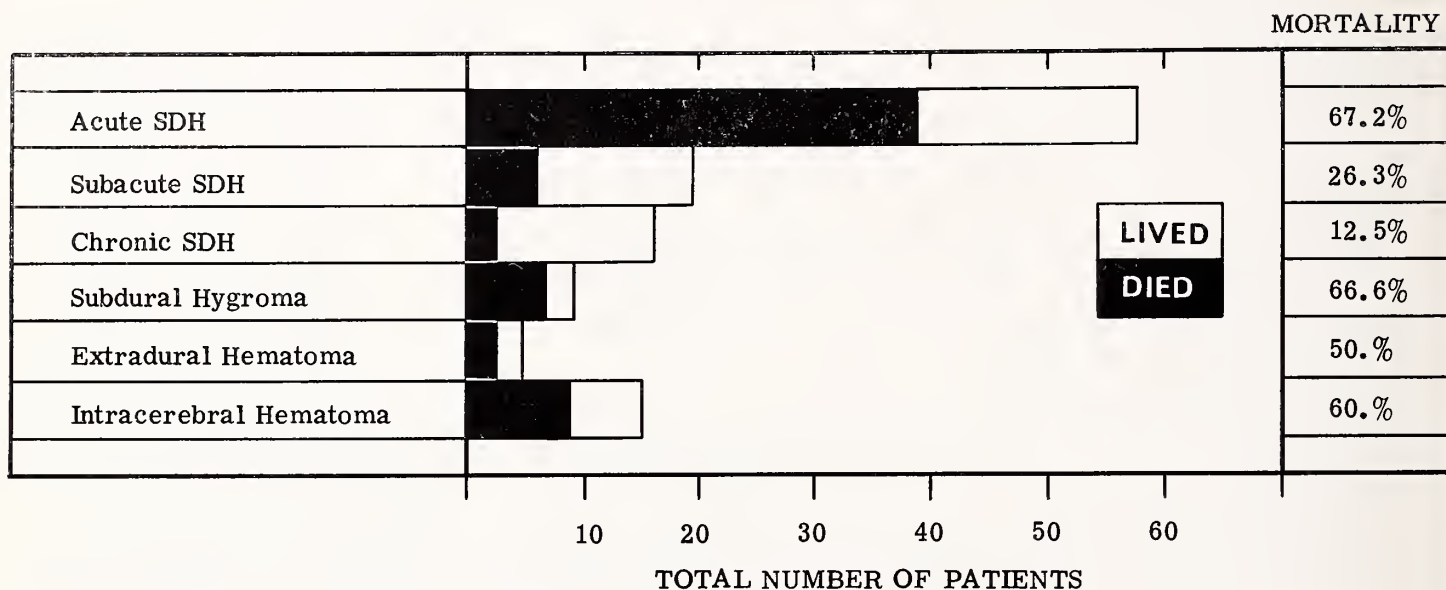
Shock must be recognized and immediately treated. While it may be true that, in adults, shock is rarely the result of head injury alone, it is equally true that, in infants, blood loss secondary to cephalohematoma or intracranial hematoma can result in shock secondary to hypovolemia. It is also possible that blood loss secondary to scalp lacerations can be massive.

Once ventilatory and circulatory competence is assured and external bleeding controlled, a rapid evaluation should follow. The physician must always complete his examination of the patient, because omissions in the rapid systematic survey of injuries, due to eagerness to treat the obvious injury, is an error that



Fig 4

## NUMBER OF PATIENTS IN EACH CATEGORY WITH PERCENT MORTALITY\*



\* Patients with more than one diagnosis are included more than once.

often leads to catastrophe. Deterioration of the patient's condition with regard to any of the organ systems automatically elevates the care of this particular injury toward the top of the list of priorities. In the case of neurologic injury, the development of a decreasing level of consciousness, hemiparesis where previously absent or a dilating pupil requires immediate attention.

It is also crucial that some injuries which may not seem immediately life threatening need to be attended to in order to prevent future complications. An example of this situation is a long bone fracture which is potentially life threatening, due to fat embolism, or an occult vertebral column injury which could result in spinal cord injury if not recognized.

In the unconscious patient, insertion of a Foley catheter when practical is not only helpful in following urinary output but is a very helpful diagnostic aid in urologic injuries. Either injection of appropriate contrast material into an IV five minutes prior to an abdominal x-ray, or the evaluation of a kidney ureter and bladder film following carotid angi-

ography is often helpful in evaluating possible urologic injury with minimal time consumption.

Management of patients with head injuries but no localizing signs includes frequent observation and re-examination of the level of consciousness, pupillary size, equality and reactivity, and extremity movement. One must not wait for the classical signs of bradycardia or blood pressure elevation, because often these signs occur late and are associated with irreversibility in a patient's condition. At the first sign of deterioration in the level of consciousness or the development of lateralizing findings, angiography is usually indicated. If, in addition to these findings, it becomes necessary to artificially support ventilation, immediate craniotomy, bypassing angiography, must be considered.

#### Mortality and Morbidity

The total mortality rate in this series was 48%. In Figure 4, it is seen that in the subdural hematoma subclassifications the mortality rate decreased with chronicity of the lesion. Our mortality for acute subdural hematomas was 67.2% com-

pared with that of McLaurin's of 64.5%<sup>8</sup> and of Lewin's of over 60%.<sup>9</sup>

The number of extradural hematomas in our series is insufficient to draw any conclusions. Jamieson, however, reported 167 cases with a 15.6% mortality,<sup>6</sup> while Gallagher reported a total mortality of 55.6% in the same number of cases.<sup>10</sup> Hooper, on the other hand, listed a 23% mortality rate in 83 patients with epidural hematoma.<sup>11</sup>

The high mortality with the intracerebral hematoma may be due in part to the fact that nine of the 15 patients had associated acute subdural hematomas. Similarly, seven of nine patients with subdural hygroma had an associated lesion which might help to explain the high mortality rate in this group.

Of the 52 patients who survived, 18 (35%) were discharged with no localized neurologic deficit, 18 were partially disabled, and 6 were totally disabled, that is, not employable.

Ten patients in this series sustained major associated bodily injury. In six cases, death was attributed to the somatic trauma. Clark and Grossman reported combined

major head and bodily injuries in 20% of 1,086 cases.<sup>12</sup> Lewin found that nearly one third of 821 cases of severe head injury were accompanied by major injury elsewhere and that nearly 10% of the deaths were secondary to the extracranial injury.<sup>9</sup> Extremity fractures were present in 50% to 70% of cases and were the most common associated injury in both series quoted above. Facial fractures were also common, while chest, intra-abdominal, and vertebral column injuries were less frequently encountered, but nonetheless important.

Of 74 patients admitted in coma, twice as many died as lived, and, of those who survived, 89% suffered residual neurologic deficit. On the other hand, of the patients in stupor, only half as many died as lived, and residual deficits were found to be present in only 58%. Only two of 16 patients admitted in a drowsy condition died, and, of the 14 survivors, six demonstrated residual neurologic deficit. Our mortality figures are quite similar to those reported by other investigators (Table VI).<sup>4</sup> Generally, we have found, as others have, a low mortality and morbidity rate in the younger patients with subdural hematomas.<sup>3,13</sup> We have also noted the poor prognosis in patients in a comatose state (Figure 5, Table VII).

Conclusions

In the population served by Marion County General Hospital, intracranial hematomas are more frequently found in adults past the age

Table VI  
PERCENT MORTALITY

Status upon Admission with Head Injury	Present Series	Rowbotham Series 1400 cases
Confused to Semicomatose	12.5%	3%
Semicomatose	29.6%	27%
Comatose	66.6%	69%

of 20. They are more likely to be subdural collections and are usually associated with signs or symptoms requiring immediate medical attention. Falls and traffic mishaps are responsible for over 70% of serious head injuries. Pedestrians receiving head injuries are more likely to be under 10 years of age, while head injuries secondary to other types of traffic accidents more often involve patients in the 10 to 20 and 20 to 40 age groups. Signs of increased intracranial pressure occur more frequently in individuals with acute subdural hematoma, subdural hygroma, or intracerebral hematoma than in other patients. The incidence of coma and death is likewise greater in these categories. Plain skull radi-

ographs are helpful in demonstrating fractures in the temporal region, thus alerting one to the possibility of epidural hemorrhage. Skull films are also of aid in demonstrating a calcified pineal gland with a shift from the midline; however, angiography has become the most efficient and effective way of diagnosing intracranial hematomas.

Emergency management of the head-injured patient must consist of the establishment and maintenance of an adequate airway, blood pressure stability, and a rapid but thorough evaluation of the patient's condition. Frequently repeated examination of the patient, along with performance of the indicated ancillary diagnostic procedures, should follow.

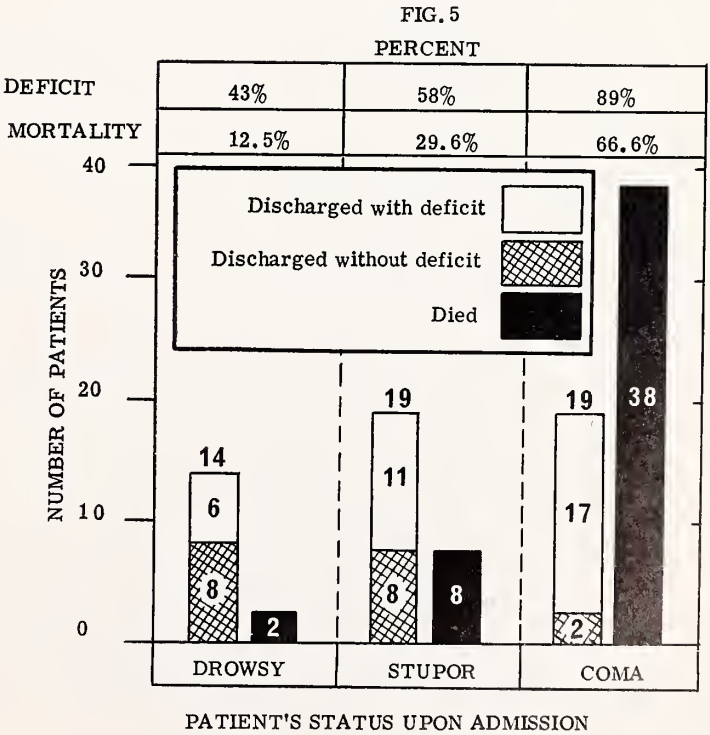
Residual morbidity and mortality correlate best with the patient's level of consciousness at the time of admission.

Summary

An analysis of 100 consecutive patients with severe injuries admitted to the neurosurgical service at Marion County General Hospital, Indianapolis, has been presented. These pa-

Table VII  
OUTCOME OF HEAD INJURY BY AGE GROUPS

Age Group	Discharged with Deficit	Discharged without Deficit	Died	Percent Mortality
0-10	11	8	1	8.3%
10-20	3	1	8	72.8%
20-40	13	1	11	45.8%
40-60	19	7	14	42.4%
60+	6	1	14	70%





tients were grouped into four basic categories, one of which was further subdivided: (1) subdural hematomas including (a) acute, (b) subacute, (c) chronic; (2) subdural hygromas; (3) epidural hematomas; and (4) intracerebral hematomas.

Each category was analyzed in terms of sex, race, age, etiology, physical findings, diagnosis, treatment, morbidity, and mortality. Methods of management with emphasis on the early recognition and treatment of concurrent injuries was discussed. Conclusions of interest and of prognostic significance were drawn from the statistical information gathered from these patients.

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### From The Journal 50 Years Ago

The treatment of peritonitis has lately attracted attention because of some remarkable results obtained at Crile's clinic. His method of treatment he insists upon in a very definite and detailed way. Through his method, out of a series of 13,415 laparotomies, he has reduced his mortality in cases of acute appendicitis alone by over 67 percent. In a personal communication he recently stated that he no longer fears any but the streptococcus types of peritonitis. Briefly his method of treatment is—

- (1) Adequate surgical drainage under anociation.
- (2) The sitting position continuously from the time the diagnosis is made through the operative and post-operative course.
- (3) Vast hot packs over the entire abdomen extending from the nipples to below the groins and well to each side, maintained *hot* twenty-four hours out of the twenty-four.
- (4) Assimilation by the patient of at least 4000 cc. of normal salt solution subcutaneously every twenty-four hours.
- (5) Morphine hypodermically until the respirations are between 12 and 14 per minute, which rate is to be held until the patient is out of danger.

Supplementing these specific factors are others such as an accurate clean cut operation done with sharp dissection and gentle manipulation and the free use of gastric lavage post-operatively. The use of Fowler's position, heat, morphine, and fluids is nothing new in regard to the treatment of peritonitis, but used in the above prescribed specific way they almost assure the recovery of any but a streptococcus variety of peritonitis, in Crile's experience.—"Recent Surgical Progress," William E. Gabe, M.D., Indianapolis, *JISMA*, July 1922.

*A three-year-old boy developed severe myopathy while receiving hydrocortisone and completely recovered when methylprednisolone was substituted.*

## Acute Steroid Myopathy

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**P**oor healing of wounds, lessened control of infection, gastrointestinal ulceration and hemorrhage, and fluid and electrolyte changes are some of the more common problems known and associated with the administration of steroids. Flaccid paresis, although described in the brochures on most steroids, is not generally well known nor recalled during steroid therapy. The use of steroids is widely accepted in preventing and controlling cerebral edema following head trauma. The paresis could mistakenly be diagnosed as a result of increased cerebral edema and not as a result of the therapy. Thus, with the increased dosage of cortisone, the situation would worsen, not improve. This case is presented to help illustrate the point. It seems to be the first recorded case of such an acute onset and recovery.

About one-half hour after eating, a healthy, three-year-old boy was run over by a riding lawnmower, creating a large wound of the left side of his body. En route to the hospital he vomited several times. Examination revealed an open left chest with loss of several ribs but without lung damage, lacerated diaphragm, ruptured spleen, evisceration of his entire abdominal contents, perforation of small bowel, transected left ulnar artery and nerve, and an oblique fracture of the ulna. The boy was

alert and never in shock.

After an uneventful surgical correction, a chest x-ray confirmed findings of aspiration in the right lung. Accordingly, he was started on Solu-Cortef, 200 mgs, and Polycillin, 3 grams, in divided doses intravenously. Appropriate intravenous fluids maintained a good output and normal electrolytes. The second post-operative day he was taking oral fluids. His temperature had decreased to 100 and pulse to 90. On the third day, he could not hold up his head and had generalized weakness and incoordination of his extremities.

Following a normal lumbar tap, neurosurgical and pediatric consultants found no evidence of increased intracranial pressure but felt the Solu-Cortef should be increased from 100 to 300 mgs for 24 hours to reduce any possible cerebral edema. In another 24 hours (fourth day), he became very weak, with abdominal distention in spite of passing flatus. On the fifth day, he was almost flaccid in spite of his alertness. He claimed he could not see, although bright lights bothered him and his pupils reacted slowly. He developed severe dysarthria. His temperature was 99 F rectally, and his pulse was 85/minute. Blood studies had been normal and on that day included sodium 142, potassium 3.6, chloride 98, CO<sub>2</sub> 36, hematocrit 36, white blood count 13,000.

That evening a detailed pharmacological review of his medications revealed the "rare occurrence of

weakness of voluntary musculature occurring with steroids, the incidence being most frequent with a 9-Alpha, fluoro-configuration and lowest with methylprednisolone." Solu-Cortef was discontinued on this finding and an equivalent 10 mgs of Solu-Medrol given intravenously. In eight hours there was the first sign of movement.

By the morning of the sixth day the boy was markedly better and, by the seventh day (36 hours after the change to Solu-Medrol), all symptoms of muscular weakness and "blindness" were subsiding. He was maintained on 20 mgs Solu-Medrol intravenously daily for two days, then tapered off in another three days. The eighth day he was walking and was neuromuscularly normal. The rest of the hospitalization was uneventful and, one year later, he is an active, healthy, four-year-old boy.

The complications and side effects of eight commonly used steroids were checked in the Physicians' Desk Reference.<sup>1</sup> In two instances, there were short descriptions of possible associated muscle weakness. Two others listed only the word myopathy in a very long list of 32 to 56 adverse reactions. The remaining four did not refer to myopathy. Numerous pharmacology textbooks do describe myopathy of steroids "characterized" by weakness of the proximal musculature of arms and legs, shoulders and pelvis. "It may occur soon after treatment is begun and be sufficiently severe to prevent ambulation."<sup>2</sup>

This young patient did not exhibit

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signs of pseudo-tumor cerebri, a well recognized complication of corticosteroid therapy in children but rare in adults.<sup>3</sup>

As studied in animals<sup>4</sup> and humans,<sup>5</sup> the pathological process of steroid myopathy is thought to begin as a massive aggregation of glycogen in the muscle fiber with basement membrane thickening followed by an intermediate phase of reversible mitochondrial alteration. Later there is a reduction of the glycogen with a breakdown of contractile elements, cellular infiltration and necrosis. The serum electrolytes usually remain normal.

This young patient exhibited involvement of all striated voluntary muscles, beginning with inability to hold his head erect. He could not use his arms or legs, follow a light with his eyes, or focus. His abdominal musculature lost its tone, develop-

ing apparent abdominal distention while having normal passage of flatus (i.e., smooth gut muscle was unaffected). In spite of these drastic changes, he remained alert without signs of increased intracranial pressure. He showed signs of improvement within eight hours when changed from hydrocortisone to a methylprednisolone and three days later all symptoms and signs had cleared. This is the first known reported case of what we believe is acute steroid myopathy with early recognition and recovery by changing the steroid therapy to a methylprednisolone that rarely produces any muscle difficulty.

In general, when signs and symptoms develop, which otherwise seem unexplainable, it may be wise to review or re-review the side effects of all drugs being administered and, in particular, to remember that a flac-

cid paresis can develop while employing certain steroids.

#### NON-PROPRIETARY AND TRADE NAMES OF DRUGS

Hydrocortisone sodium succinate—  
Solu-Cortef  
Methylprednisolone sodium succinate—  
Solu-Medrol  
Ampicillin—Polycillin

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## Slipped Capital Femoral Epiphysis

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### Introduction

**S**LIPPED capital femoral epiphysis is a disease of young adolescence which has been recognized since 1572. If this disease is diagnosed early and treated promptly, a good result with little disability can be expected. If the diagnosis is missed or delayed, permanent disability resulting from hip deformity and early degenerative arthritis may result. The key to early diagnosis is to think of the possibility of having the disease—then follow through with a careful exam of the hip and have good x-rays taken. *Any child between 8 and 16 who complains of persisting pain in the hip, thigh or knee—or who walks with a limp—should be evaluated for a slipping proximal femoral epiphysis.*

In spite of increasing awareness of this condition, many cases are missed each year, being passed off as muscle strains, knee sprain, flat feet (!) or "growing pains" by competent physicians. The diagnosis is missed because the disease often has an in-

sidious onset with a slowly progressive course. Symptoms of pain may be missing in the hip area—being referred to the thigh or knee. Hip x-rays may at first show only subtle changes. The A-P view may seem normal with early slipping evident only on a good "frog" lateral. If diagnosis is delayed until the radiological and physical findings are quite obvious, the epiphysis may have slipped far enough to have caused marked deformity of the hip—deformity requiring major hip surgery and prolonged convalescence. Such was the case in a 15-year-old

patient seen recently who was referred to us after an 18-month history of "knee pain." The patient had been treated by elastic wrapping of the knee after examination and x-rays of the knee showed no significant abnormalities. His hip epiphysis was fused in marked varus (bowing) deformity with shortening causing a gross limp and marked limitation of hip motion (Figure 1). With this background of the danger of a missed diagnosis in mind, it is a good idea to review the course of this disease, its symptoms, physical findings and the x-ray findings.

**THIS x-ray** shows a severe chronic slipping of the right proximal epiphysis. Without major hip surgery the patient, a 15-year-old boy, will have permanent and significant disability. The patient had complained for two years of "knee pain" but diagnosis was delayed until the patient developed a gross limp. Early diagnosis might well have prevented this course of events.



FIGURE 1

\* From the Department of Orthopaedic Surgery of St. Vincent Hospital, Indianapolis, Department of Orthopaedic Surgery, Indiana University School of Medicine, 1100 W. Michigan St. Indianapolis 46202.



## What Is Slipped Capital Femoral Epiphysis?

Slipped capital femoral epiphysis is a *gradual* slipping of this epiphysis backward and downward. This causes disabling external rotation and shortening deformity of the lower extremity. It occurs in adolescent children during the rapid growth period when the epiphyseal attachment seems to be weakened. Boys are affected more often than girls. The etiology remains unknown but is most likely related to endocrine imbalance in combination with continuing mechanical stress across the epiphyseal plate area. The fact that tall thin children or short Frohlich type individuals are affected more often than children with normal growth supports endocrine theories of etiology.

The disease can be divided into three stages. The first or "pre-slipping" stage is characterized by mild symptoms and signs due to synovitis. The second or slipping stage has similar but more marked symptoms with more definite clinical and x-ray findings. The third stage is the healing stage with fusion of the growth plate and decreasing

symptoms. A residual stage may be added with permanent deformity and osteoarthritis.

### What Are the Symptoms and Signs?

The early symptoms result from mild synovitis. There is moderate or slight pain, limp and stiffness. The pain is worse with activity. It may be in the groin, inner or anterior thigh or inner side of the knee. With more slipping the pain may be worse. The child may not be able to walk. There may be exacerbations of pain with symptom-free periods. The residual symptoms are those of deformity—a limp due to shortening and external rotation and later symptoms resulting from osteoarthritis.

The early signs (pre-slipping) are limp and limitation of abduction and internal rotation due to muscle spasm. Slipping causes shortening, external rotation, more limitation of abduction and internal rotation, and more muscle spasm. When the hip is fully flexed the knee will go lateral to the chest because of the external rotation and abduction deformity. Late signs are those of osteoarthritis. All lab values are normal except for a slightly elevated sedimentation rate.



FIGURE 2

A-P x-ray of the left hip of a nine-year-old girl. This is a moderately severe slip. The true degree of slipping is much more apparent on the lateral view in this patient.



FIGURE 3

LATERAL x-ray in the same patient as in Figure 2. The amount of slipping, especially in the posterior direction, is easily seen. Note the prominent "bump" on the superior neck. Range of motion was greatly improved in this girl by surgical removal of this bump.

### X-ray Findings

X-rays confirm the diagnosis and are useful in following the course of therapy. The opposite hip must always be taken for comparison. It is imperative to take both A-P and lateral views. Early changes seen are swelling of the joint capsule and decalcification, widening and irregularity of the epiphyseal line. Later changes show downward slipping on the A-P view and posterior slipping on the lateral x-ray. Varus deformity becomes more marked with a prominent superior "corner" forming on the femoral neck at the point where the head slips on the neck. (Removal of this "bump" can sometimes greatly improve hip motion. This was done later on the hip of the patient shown in Figure 2 with a gratifying improvement in function.) Late x-ray changes show less swelling but may reveal joint space narrowing, aseptic necrosis and osteoarthritic changes. (See Figures 2 and 3.)

### Summary

Early diagnosis and treatment of slipped capital femoral epiphysis is essential. Poor results of treatment are directly related to delay in diag-



nosis. Disability may be severe. Suspect the diagnosis in any child between 8 and 16 with a limp, pain in the hip, thigh, or knee, and limitation of hip motion with muscle spasm. Examination of the hip must be carefully done. As soon as the diagnosis is suspected the child must be taken completely off weight bearing and x-rays must be taken. Be sure to order lateral views.

If there is any doubt, the child should be kept off weight bearing until serial x-rays prove or disprove the diagnosis. Orthopedic consultation should be sought. Many cases require surgery ranging from simple pinning *in situ* to major hip surgery. The most important aid to diagnosis is to think of the possibility, carefully examine the hip, and obtain good x-rays.

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# Drug Interactions and Diuretic Therapy

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THE present availability to the physician of a number of potent diuretics offers a wide choice of agents with varying pharmacology. He must decide when to use diuretics and be able to integrate the drug's pharmacology with the patient's pathophysiology, as well as be alert to possible drug interactions due to the patient concurrently taking other drugs.<sup>1</sup> The efficacy and rapidity of action of these diuretics impose on the clinician a greater burden of knowledge and better patient monitoring during this therapy than in the past.<sup>2</sup>

Diuretics may cause a reduction in the normal ratio of sodium to water in the plasma by depleting the body of sodium since they are natriuretic agents. The patient suffering from sodium depletion will exhibit, in contrast to the overhydrated subject, weight loss, postural hypotension, worsening renal function, and possibly even shock.<sup>3,4,5</sup> Sodium chloride replacement has been shown to be the appropriate treatment for this condition.<sup>3</sup>

Diuretic therapy is probably the most common cause of hypokalemia in clinical practice today.<sup>6</sup> Potassium depletion is thought to occur as a consequence of an increased delivery of sodium to the distal nephron under circumstances in which aldosterone secretion is high; the activity of the sodium-potassium exchange is increased such that sodium is reabsorbed, and potassium is excreted in its place. Appropriate

therapy is (a) stop the diuretic; (b) administer potassium replacement, preferably in the form of KCL; or (c) administer either spironolactone or triamterene while watching closely for evidence of developing hyperkalemia.<sup>6,7,8,4</sup>

A number of other less frequently encountered side effects have been described in association with diuretic therapy. Carbohydrate tolerance may worsen in prediabetics and diabetics, particularly with the administration of thiazides. Its cause is unknown, but this effect has not been described in normal subjects on thiazide. However, this effect on normal subjects has been observed with chlorthalidone.<sup>8,10</sup> Another side effect of diuretic therapy is brought about by a reduction in the renal clearance of urates and leads to hyperuricemia with ensuing clinical gout.<sup>7,8,9</sup> If the patient is concurrently taking aspirin in an OTC product and, in addition, ingesting alcoholic beverages, then even a higher risk of clinical gout may be encountered.<sup>11</sup> Counseling of this type of patient by the clinician and/or the pharmacist may decrease the frequency of such adverse reactions. Fortunately, uricosuric agents—such as probenecid, or xanthine oxidase inhibitors—such as allopurinol, are effective in reversing this complication. Excessive diuresis may cause dehydration resulting in hypovolemia, cause onset of pancreatitis and myopia in some patients.<sup>7,8,9</sup>

Diuretics must be employed with caution in chronic renal failure with oliguria, contraindicated in all phases

of anuria and discontinued if azotemia and oliguria occur during any therapy. However, a more recent study has shown that 25% of patients on tetracycline therapy and concurrently taking diuretics will show a significant rise in their BUN.<sup>12</sup> Thus, the physician must again evaluate whether to discontinue therapy or not. Demonstrated hypersensitivity and severe hepatic disease are other contraindications of diuretic therapy.<sup>7,14</sup> All these compounds should be used with caution in pregnancy due to their producing fetal or neonatal hyperbilirubinemia, thrombocytopenia or altered carbohydrate metabolism.

The effects that the diuretic agents have on the electrolytes and fluid balance in the body, in addition to specific direct actions they have on the various physiological systems, make them prime candidates for many types of drug interactions.

In diuretic therapy many clinical advantages are gained by interactions of diuretics combined with additional diuretics or other classes of compounds. Diuretics that act by increasing osmotic pressure in tubular filtrate, such as mannitol, may be combined with other diuretics such as spironolactone or triamterene to enhance diuresis, as these compounds act at different sites along the nephron unit.<sup>14</sup> Spironolactone may be combined with mercurial or thiazide diuretics in order to obtain a more prompt diuresis and decrease potassium loss.<sup>6,9,10,15,16</sup> A glucocorticoid may be added to this regimen in order to facilitate GFR and further

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enhance diuresis.<sup>1,6,8</sup> Triamterene is combined with furosamide or ethacrynic acid in order to produce a greater diuretic effect while decreasing dosages of both compounds and lessening potassium loss to the patient.<sup>2</sup> The advantage of following a refractory mercurial diuretic with a urinary acidifying diuretic agent (e.g., ammonium chloride) or with acetazolamide, which causes a diuresis resulting in a hyperchloremic systemic acidosis, is well documented.<sup>1,8,9</sup> Mercurial diuretics are combined with xanthines and by taking advantage of the increased GFR produced by the latter, a greater diuretic action occurs.<sup>8</sup> Guanethidine and *alpha* methyldopa are combined with thiazide diuretics to improve therapy in hypertension.<sup>17</sup> As a result of the combined hypotensive effects, the dosage of the more potent guanethidine or *alpha* methyldopa may be reduced and better patient management of the hypertension is maintained, without resulting in such side effects as orthostatic hypotension. The advantage of the combination of diuretics with *alpha* methyldopa is seen, not only in better hypotensive effect resulting in lower doses of *alpha* methyldopa, but also in the diuretic counteracting the weight gain and edema resulting with *alpha* methyldopa therapy.<sup>5,17</sup>

The potassium sparing effect of triamterene has led to its use with thiazide diuretics in order to provide an enhanced diuresis with reduced potassium loss.<sup>6,8</sup>

However, as a class, mismanagement of diuretic therapy has led to acute hypovolemia, hypotension and, with ethacrynic acid, acute hypotension bordering on shock.<sup>2,8,15</sup> Other classes of agents that are combined with diuretics inadvertently or advertently may result in orthostatic or postural hypotension.<sup>17</sup> These classes of drugs include central nervous system depressants, such as alcohol, barbiturates, narcotics;<sup>3,10</sup> psychotropic agents, such as chlorpromazine, reserpine, tricyclic and

the MAO inhibitors anti-depressants<sup>4</sup> and the non-thiazide diuretic and hypotensive agent, chlorthalidone and methyldopa.<sup>5</sup> In fact, thiazide diuretics summate or potentiate hypotensive agents, producing excessive decrease in blood pressure. These include the rauwolfia and veratrum alkaloids, hydralazine, and any of the ganglionic blocking agents.<sup>3,5,17</sup>

The combination of chlorpromazine and thiazide diuretics has been reported to produce a hypotensive shock refractory to metaraminol (a sympathomimetic hypertensive agent) because of chlorpromazine's peripheral *alpha*-adrenergic blocking action.<sup>3,9,18</sup>

Systems other than the cardiovascular system are affected by thiazide interactions. The hemopoietic system regulation by coumadin is *unbalanced* in the presence of diuretic therapy. The diuretics furosamide and ethacrynic acid have been shown to antagonize anticoagulants because of inducing a rapid diuresis which may result in inducing formation of emboli and vascular thrombosis by increasing the rate of removal of the anticoagulant.<sup>10,19</sup> This combination has been demonstrated to decrease prothrombin time as determined by the Quick one-stage test.<sup>8,13</sup> The effects of diuretics on the oral hypoglycemic agents are well documented. All (i.e., thiazides, furosamides, triamterene, ethacrynic acid, etc.) have been demonstrated to increase the blood glucose level most probably through depressing insulin secretion.<sup>4,9,20,21,22,23</sup> The additive actions of corticosteroids and potassium depleting diuretics such as furosamide, thiazide, and ethacrynic acid may result in hypokalemia.<sup>8</sup> These diuretics must be used with caution in digitalis therapy as its toxicity may be enhanced in hypokalemia.<sup>8,24,25</sup> The combination of kanamycin and ethacrynic acid has resulted in destruction of the eighth cranial nerve and irreversible deafness.<sup>8,26,27,28</sup> This can be avoided by using a thiazide diuretic instead.

Thiazide diuretics have been shown to decrease arterial responsiveness of norepinephrine, which lessens its pressor activity.<sup>10,16</sup> All diuretics that produce hypovolemia may potentiate the action of muscle relaxants such as curare, succinylcholine and gallamine by prolongation of the repolarization phase of the muscle's action potential.<sup>4,29,30</sup> This may result in prolonged respiratory paralysis. Increased dosages are needed with uricosurics (i.e., phenylbutazone, sulfurpyrayone, probenecid) in the presence of ethacrynic acid and theophylline diuretics, due to their ability to decrease uric acid secretion by renal tubules.<sup>8</sup>

In summary, diuretic therapy must be conservatively employed in patients with impaired renal function or in patients in various stages of dehydration due to excessive vomiting or diarrhea from other causes. When diuretics are combined with any other drug therapy, only close patient monitoring can avoid potentially hazardous situations.

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# *The Public Health Implications of the Presence of Hepatitis B Antigen in Human Serum*

A Statement By

The Committee<sup>1</sup> on Viral Hepatitis

of the

Division of Medical Sciences

National Academy of Sciences—National Research Council

EPIDEMIOLOGIC data for the United States since 1966 show steady annual increases in the incidence of type B hepatitis (serum hepatitis) and in its proportional representation among all reported cases of viral hepatitis, including type A (infectious) hepatitis. It is now recognized that, in addition to the well-established parenteral mode of transmission, type B hepatitis can be transmitted by other means. During the last few years, a clearer definition of the significance of type B hepatitis as a clinical and public health problem has risen from the discovery, development, and widespread application of various serologic tests for the presence of an

antigen, hepatitis B antigen<sup>2</sup> (HB Ag), that is associated with the disease.

The demonstration of the antigen in the serum of a patient or of an apparently healthy person raises questions not only of the presence of active liver disease, but of the potential risk of his transmitting the infection to others.

On the basis of information acquired from clinical and epidemiologic studies and from antigen testing programs, the Committee on Viral Hepatitis finds that:

1. A positive test is indicative of the presence of acute or chronic type B hepatitis or of the asymptomatic carrier state.

2. The presence of the antigen in the serum of a patient with acute type B hepatitis is usually transitory. If it persists for more than three months after the onset of illness, the person is likely to become a chronic carrier of the antigen.

3. The chronic carrier of the antigen may or may not have readily demonstrable evidence of related liver disease.

4. Although the infectiousness of patients with antigen-positive hepatitis apparently diminishes when the antigen is no longer demonstrable in the serum, they are not acceptable as blood donors.

5. There is clear evidence that carriers should be prohibited from donating blood for transfusion.

6. There is insufficient knowledge of the extent to which chronic carriers can transmit type B hepatitis by nonparenteral routes.

The Committee recommends that:

1. When a person is found to have a positive test in the course of diagnostic studies, blood donor testing, or testing after exposure to a known risk of infection with type B hepatitis, he be so informed and the test be repeated promptly on a later sample of serum; and a person with a confirmed positive test be evaluated for the presence of liver disease and followed to determine whether the antigen persists.

2. Patients with acute antigen-positive hepatitis be considered infectious and control measures be taken with respect to potentially infectious materials such as blood and blood-contaminated secretions.

3. Testing be required of all blood donors, although, with respect to risk of transmission to others, there is

<sup>1</sup>R. W. McCollum, Yale University School of Medicine, New Haven, Conn., Chairman; M. B. Gregg, Center for Disease Control, Atlanta, Ga.; E. A. Kabat, Columbia University, College of Physicians and Surgeons, New York City; S. Krugman, New York University School of Medicine, New York City; J. L. Melnick, Baylor College of Medicine, Houston, Texas; A. G. Redeker, University of Southern California, Los Angeles, Calif.; and P. E. Taylor, Canadian Communicable Disease Centre, Ottawa, Canada.

This statement has been endorsed by the American Association of Blood Banks, the Committee on Transfusion and Transplantation of the American Medical Association, and the American National Red Cross.

<sup>2</sup>This antigen has been referred to as Australia antigen (Au Ag), hepatitis antigen (HA), serum hepatitis (SH) antigen, and hepatitis-associated antigen (HAA).



no reason at this time to recommend routine testing of any specific professional or occupational group or of all hospital patients.

4. Until more complete knowledge of the significance of the antigen carrier state is acquired, particularly as to its prevalence and its relation to communicability, no routine precautions be instituted beyond those which apply to percutaneous routes of potential transmission.

5. Because standard Immune

Serum Globulin (ISG) is of no demonstrable value in the treatment of carriers, it not be used for this purpose—nor is there adequate evidence to recommend the use of standard ISG for prophylaxis among contacts.

6. An intensified effort be made to report hepatitis cases—on the basis of serologic test results, as well as epidemiologic characteristics—in order to improve surveillance on a national basis.

### Acknowledgment

The preparation of this statement was made possible by funds provided under a contract with the National Institutes of Health (PH43-64-44, Task Order No. 56).

While this statement in its final form may not necessarily have their endorsement, the Committee wishes to acknowledge the contributions of Dr. Baruch S. Blumberg, Dr. Thomas C. Chalmers, Dr. H. Bruce Dull, Dr. Paul J. Schmidt and Dr. Hyman J. Zimmerman. ◀

## About Our Cover

The painting was made at request of Dr. Frank B. Ramsey, editor of our Journal. It has a spring scenery for promotion of "peace," particularly peace in the Orient. The swans in center of the painting are new "peace birds." When President Nixon presented mute swan to mainland China, the swan was called peace bird. Bamboo is a symbol of Orient. Dr. Loh's original painting also had a plum tree which was later replaced with peony by his painting teacher, Mr. Woo Lu Chuan, because the latter flower would be more colorful. Both the plum flower and the peony flower have been national flowers of China. Six fish are also seen in the spring water. They do not seem to be disturbed by the swans and certainly can add peace and tranquility to the scenery. The painting also carries Dr. Loh's name and his teacher's name in Chinese.—W. P. L.

Dr. Loh is the chief pathologist for the Gary Methodist Hospital and the Lake County Coroner's Office. He is also a part-time clinical associate professor at the Chicago Medical School. When he served as a visiting professor at the National Taiwan University in Taipei last year, he spent every evening and night learning the Chinese water color painting on silk (Lingnan style) from his teacher, Mr. Woo. At 1971 ISMA convention Dr. Loh won first and second place awards for water-color painting.

Reproduction of the painting was made possible by the assistance of the Mary Rogers Fund.

The Journal is pleased to offer its readers, free of charge, a full-size, full-color reproduction of Dr. Loh's "Peace" painting, suitable for framing.

It is requested that the adjacent postal be completed and returned by August 1.

# *The Journal* of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## Tips from the Tower

*The Journal* is inaugurating a new feature—"Tips From The Tower"—a monthly column for clinical subjects which are suitable for brief discussion. The column will be edited by Dr. A. Alan Fischer, director of the Family Practice Program, Indiana University School of Medicine. It will be written, in response to questions and requests of the readers, by members of the faculty of the School of Medicine. Requests are invited from readers of *The Journal*. Inquiries related to general medicine or any of the various specialties will be welcome. Correspondence should be addressed to Tips From The Tower, % Dr. A. Alan Fischer, Family Practice Program, 1100 W. Michigan St., Indianapolis 46202.

## Medical Civics

*THE* Medical Civics course which is offered to the students of the Sophomore Class of Indiana University School of Medicine continues to grow and develop and has been adapted to the changing times and changing methods of medical practice with admirable facility.

As stated in the course introduction by Dr. Donald E. Wood, chairman of

the Department of Medical Economics:

"The course has three purposes. It is designed to define the interrelationships between the physician and society, to sensitize medical students to the determinants of health care, and to delineate the alternatives in health care delivery systems. These purposes are to promote intelligent evaluations and participation whenever possible.

"The judicial, ethical, moral, religious and sociological interrelationships will be discussed principally through the panel participation. There will be a mock trial based on an actual case illustrating courtroom procedure.

"Health care will be discussed as to the basic resources of manpower, facilities and bio-medical knowledge as well as the organization and financing mechanisms necessary to translate these resources into health services for the consumer. The political issues and realities will also be discussed.

"Just as it is impossible to master the whole internal medicine or surgical picture in medical school, it is likewise impossible to become completely acquainted with the problems of economics, ethics, law, sociology and the organizations of health care

delivery systems. The subject matter of these additional disciplines is becoming increasingly relevant for the medical school curriculum. Our intent is to acquaint the undergraduate and graduate medical students with a basic understanding of these areas of study as they relate to the practice of medicine. Hence, the course should be viewed as a framework for continuing education in the interdisciplinary problems surrounding health care delivery and an attempt to enable a more creative physician response to the pressing health problems of contemporary society."

The course occupies solid time from 8:00 a.m. until noon, on six days. Attendance figures are high although attendance is not compulsory.

"The Law and Medicine" is covered by lectures on medical jurisprudence and negligence in medicine and by the mock trial.

"Health Care—Delivery and Manpower" is discussed from the viewpoint of pediatric nurse assistants and family practice nurse assistants, and of the physician's assistant program. Innovations in the organization of the health care system as applied to development of family practice, the Permanente type practice and by group practice are outlined in a panel discussion.



One day is devoted to problems. Problems of the health care of the black race, problems of osteopathy, problems of social work and medicine and problems of the AMA are all detailed in one morning.

Medical legislation is the topic for another morning's discussion. Health legislation is also discussed on yet another day, this time by the Mayor of Indianapolis.

Medical ethics is the subject for a complete morning program before the class launches into a full program on population control, abortion and planned parenthood.

The course attracts a wealth of talent and outstanding authorities, both from the state and nation. The dean of the IUPUI Law School, the dean of the School of Medicine, Dr. John G. Smillie of the Permanente Medical Group, the president of the National Medical Association and a past president of the AMA have all participated.

Other out-of-state speakers have been the dean of the Chicago School of Osteopathy; Dr. Russell Roth, speaker of the AMA House of Delegates; several representatives of the Department of Health, Education, and Welfare; and Dr. Allan Barnes of the Rockefeller Foundation.

Many national medical meetings are conducted with a less distinguished group of authorities. Certainly sophomores at Indiana University School of Medicine enter their third and fourth years in school with a full realization of the problems and intricacies of the practice of medicine and the civic obligations of physicians.

### Substitution Legal in Kentucky

THE Kentucky legislature has passed and the Governor of Kentucky has signed a bill which allows pharmacists to substitute brands other than those prescribed and gives the purchaser the right to demand any form of the drug which is

listed in a formulary which a Drug Formulary Council will establish.

A prescribing physician may prevent substitution by writing on the R<sub>x</sub> "Do Not Substitute." This must be written and cannot be preprinted on the prescription blank. The unhandy element in the situation is that the admonition must be written by the physician and cannot be dictated in the case of a telephoned prescription.

The law was favored by the American Pharmaceutical Association and by the Kentucky Pharmaceutical Association. It was opposed by the Kentucky State Medical Association and the Pharmaceutical Manufacturers Association. It passed the state Assembly by 66 to 22 and the Senate by 34 to 0.

The Drug Formulary Council is to be composed of the pharmacology department chairmen of the University of Louisville and the University of Kentucky medical schools; the dean of the University of Kentucky pharmacy school; two physicians; one pharmacist; one consumer "in no manner connected with the health care field"; one member of the legislature; and one member selected at the discretion of the governor.

The formulary will be available to the general public. The idea is to educate consumers so that they will be in a position to request substitutes intelligently.

The formulary is supposed to list therapeutically equivalent drugs. This comes at a time when there is considerable doubt that therapeutic equivalency exists in all drugs and, if it does, how it is to be determined.

"Action in Pharmacy" in commenting on the bill says: "The final judgment as to what in fact is therapeutic equivalency may turn out to be in the Supreme Court of the state of Kentucky if a patient adversely affected by one of the "therapeutically equivalent" drugs should choose to bring action against the pharmacist and the Formulary Council

for damages resulting from the use of these drugs when the doctor had prescribed a different product.

The law requires that, in case another brand or formulation of the drug is substituted, the name of the drug dispensed and the name of the drug prescribed should appear on the label.

### Guest Editorials

#### Hospital Costs: Sense and Nonsense\*

I am distressed in my readings of the daily press to find that a new national system of health insurance will solve all the problems that Medicare and Medicaid were supposed to solve.

My great fear is that we will again assume that new legislation, which some of its protagonists insist will cost us nothing (!), will give us all the answers which we have been unable to work out previously.

I do not contest for a moment that serious deficiencies exist in our present nonprofit and commercial insurance, but I am not able to discover how these defects are supposed to be remedied and a lot of other ones in addition by recourse to a national system.

For years economists have been unsettled by what might be called the vulgar liberalism of the American businessman who sings the praises of the free market while engaging in all kinds of restrictive practice and in addition seeks favors from the government.

The medical reformers seem to me at least to be engaged in a similar game of assuring the public about the values of a national health insurance system without indicating how this model is supposed to produce

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\* Excerpted from an address to the Association for Hospital Medical Education, February 1970, which appeared in the January 1971 issue of Viewpoint.

Dr. Ginzberg is Professor of Economics and Director, Conservation of Human Resources, Columbia University.

the results which they seek and the public needs. . . .

The critical point is that the nation is pushing against the ceiling of real resources. We no longer have any large number of excess workers or excess capital to play with. This is the critical issue in financing mechanisms.

The problem faces us not only with respect to medical care but also in education, urban renewal, environmental control—in fact, with respect to everything that needs doing and that we want to do. . . .

With respect to the shortcomings of insurance I am in favor of improving major medical which, in my opinion, with its sizeable deductible, is what most of middle-class America needs and wants. Since I do not believe that we can guarantee a high level of medical care for the entire American public I want to be careful about how to improve the present imperfect structure.

One way, as I have just suggested, is to strengthen major medical insurance.

The other is to work out some special approaches to the urban and rural poor so that they can gain more access than they now have to the system. In the cities I would try to link them to the major teaching hospitals. In the countryside I would stress public health nursing and improved transportation to urban hospitals. . . .

In 1940, the per diem hospital cost in New York City was \$7. In 1955, it was approximately \$30. In 1968, it averaged about \$110. Clearly, hospital costs have been rising over a long period and I see no prospect for them to do anything else but to continue to rise. The critical question, however, is at what rate. . . .

Let us face up to the fact that we have never had, we do not now have, and we will never have enough money to practice the best type of medicine that we are capable of practicing for all the people of the country. We live

in a world of limited resources and the public in the last analysis must decide through the legislature, through insurance, and through direct payments how much of its total budget it is willing to allocate to health.

The decisions about health are now directly in the political arena. But it behooves all of us to remember that politics like the market is a potential but limited instrument and that it is no more capable of creating bricks without straw than is the private entrepreneur.—**Eli Ginzberg, Ph.D., *Delaware Medical Journal*, January 1972. Reprinted with permission.**

### A Vote Against Antisubstitution Repeal

**U**NLESS some compelling arguments have been overlooked, I can see no justification for the current campaign by the American Pharmaceutical Association for repeal of state antisubstitution laws. It is divisive, self-serving and unworthy of a professional organization that claims to be concerned about interdisciplinary efforts to improve health care for America.

Many of the serious implications of this campaign are discussed elsewhere in this issue by Dr. Thomas W. Fiss, Jr., an associate editor of TNP.

No one quarrels with recent efforts by pharmacists to define a broader role for themselves in the delivery of health care. It is well recognized that modern pharmacists are over-educated for the tasks they routinely perform. The professional plight of the pharmacist was studied recently by a task force formed by the Department of Health, Education, and Welfare, which commented on this waste of professional resources in the opening statement of its report: "The pharmacist is a health resource whose potential contribution to patient care and public health is grossly underdeveloped and which, thereby, is used ineffectively."

Anyone familiar with health-care issues would have to agree. And certainly efforts to utilize this "resource" more efficiently should be applauded. How, then, does this relate to the campaign for antisubstitution repeal?

The APhA contends that legalized free substitution would help solve the problem of underutilization by giving pharmacists new responsibility. They would choose the source of a drug when the physician prescribes by brand name a therapeutic agent available from several manufacturers. Certainly this is a new responsibility, but is the pharmacist prepared for it—educationally, professionally or ethically?

In the dispensing of broad classifications of drugs used for the symptomatic treatment of minor illnesses, no objective physician would complain about substitution of an "equivalent" product. But doctors also rely on a wide spectrum of potent therapeutic agents in the management of patients with serious chronic diseases. Here, if they insist on brand-name products—for any reason—their wishes should be honored. There is a growing body of data indicating that drugs marketed as chemical equivalents do not result in equivalent blood levels. Recent experience with varying therapeutic effectiveness of digoxin preparations marketed by different manufacturers is, perhaps, the most dramatic demonstration of this problem.

Physicians who are following patients on chronic drug regimens might be confused by varying therapeutic response to unstandardized "equivalent" products. Prescription by brand name indicates confidence in the manufacturer and experience with the particular product. Given this information, how can anyone claim—as the dean of Ohio State University's College of Pharmacy did recently—that the pharmacist "as much as, if not more than the physician . . . has the knowledge and understanding on which he can make



a rational judgment as to the brand of drug to dispense"? This implies a clinical competence beyond the present training and experience of pharmacists and erects an unnecessary uncertainty between the physician and implementation of the therapeutic regimen he designs. As such, it is and should be unacceptable to the medical profession.

Some efforts are being made to give the pharmacist a measure of clinical competence. In a few training programs in "clinical pharmacy," students consult with patients about a variety of drug-related problems and are available to advise physicians in their area of competence. These programs are commendable and, hopefully, will help to forge a new role for the pharmacist—but they do not give him license to substitute his judgment for that of the physician, who has the legal and moral

responsibility for the care of his patients.

The solution to this controversy should not be legal or political action forcing physicians to surrender some of their responsibility. To develop a new and honored status for the pharmacist does not require diminution of the doctor's role in patient care. Those pharmacists who are determined to have ultimate clinical and therapeutic responsibility should apply for admission to medical school. The others—those content and proud to be pharmacists—can find a host of interesting and challenging problems worthy of their sophistication. And during any moments of depression at being overtrained for the routine tasks required of them, they might consider for a moment that doctors are overtrained for most of the things they do.—**T. S. Carden, Jr., M.D.,** *The New Physician* May, 1972. Reprinted with permission.

**AMA.—Edward Siegel, M.D.,** President of the Medical Society of New York.

## Editorial Notes . . .

**The Pharmaceutical Manufacturers Association reports that at least six narcotic antagonists are in various phases of pre-clinical or clinical trial.** Research in treatment of withdrawal symptoms is also continuing with promise of good results. There is one new compound which, when given to addicted monkeys, develops a revulsion to morphine.

**Patients with advanced kidney damage and uremia and those treated with the artificial kidney often develop low levels of calcium, decreased amounts in the bone, and impaired absorption of calcium from their food.** They resemble rickets but do not respond to standard forms of Vitamin D. The Veterans Administration has identified another form of Vitamin D which is produced by the human kidney. It is able to bypass the kidney defect and is useful in maintaining calcium metabolism in uremic patients. Research is now in order to determine how to synthesize the new form since the supply from natural sources is very expensive.

**Wheat and barley seed, coated with methylmercury as a fungicide, shipped from Canada to Iraq, has caused the death of several hundred Iraqis.** Despite adequate signs and warnings to limit the grain for planting use only, it was used to feed cattle. When the cattle sickened they were rushed to the slaughterhouse. The meat was sold for food and poisoned humans. Recently the U.S. Environmental Protection Agency has severely restricted the use of alkyl mercury pesticides.



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## Who Needs the AMA?

THE eternal cry is raised, who needs the AMA? What does it do for me? It's too liberal! It's too reactionary! It's too conservative!

Anyone who has followed the AMA knows that the voices of dissension and criticism are now being heard in that organization. As all organizations must change to survive, the AMA is changing. What direction it takes depends on those of you who are interested enough to have a part of the action.

There is not a single physician in this country today who has not benefited from the AMA when one considers the fantastic amount of work that they have done on a national scale in all facets of medicine and public health. A look at their journals, magazines, committees, councils, and task forces will vouch for this.

I think it is morally unacceptable for us to share in the benefits of the AMA without supporting the



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**Contraindications:** Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

**Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

**Precautions:** Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, consti-

pation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in EKG tracings.

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**For Trichomoniasis. In the Female:** One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used, one 500-mg. insert is*

placed high in the vaginal vault each day for ten days and the oral dosage reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. **In the Male:** Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of the female partner.

**For Amebiasis. Adults:** For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days.

**Children:** 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, orally for ten days.

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**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $> 5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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## IN EDEMA\* — IN HYPERTENSION\*



*This article details the use of a Physician Assistant in general practice in a community of approximately 50,000 people. Included in the presentation are the training of the Physician Assistant, the early months in the office with the Physician Assistant, and the key areas of his responsibility. Finally, a view of how Physician Assistants may help physicians with the ever more demanding task of health care delivery and how this may help alleviate the health manpower shortage is discussed.*

## Physician Assistant: One Year With General Practitioner

DAN W. HIBNER, M.D.  
Richmond

### Background

EARLY reports and articles regarding Physician Assistants made it clear to me that my practice could utilize such a person. I was partially convinced because of previous experience with Navy Corpsmen, and especially persuaded by a busy practice that offered many opportunities for screening and "co-operative practice."

After considering three candidates, I hired a previous Air Force Corpsman who had had some sales experience with good recommendations and, most importantly, was a 1970 graduate of the Cleveland Clinic Physician Assistant Program.

### The Practice Setting

At the time of considering this move I had been in general practice in Richmond five years. During most of this time I practiced with another physician in a loose association, sharing common office space and personnel. For convenience and clarity of channels of responsibility, the Physician Assistant was employed by me rather than the association and was responsible in the main for

helping with my practice. This practice arrangement resulted in an interesting test of the concept of a Physician Assistant's usefulness which I shall discuss later.

### The Early Months

It was decided to announce our plan to my patients and to the medical community well in advance. A letter sent to patients announcing the Physician Assistant's arrival indicated his position as an assistant and specified he would be assisting the doctor in certain office and home health tasks. It was plainly stated that he was not, and was not in training to become, a physician.

In order to make the plan clear to the medical community, my anticipated use of the assistant in the office was presented to the Executive Committee of the medical staff of the local hospital and the Liaison Committee of the hospital board. The assistant was introduced to the hospital administration with clarification of his presence in the hospital. At the outset *no* hospital privileges were requested. It was clearly understood that he was to accompany the physi-

cian in any and all hospital work simply for training and that he was to assume no hospital responsibilities.

In the office we arbitrarily set aside three months during which nearly all but the simplest tasks were undertaken jointly by the physician and Physician Assistant for two reasons:

- (1) To provide the latter with office training to supplement his hospital-based training at the Cleveland Clinic.
- (2) To provide each of us an opportunity to understand clearly the concepts and objectives that we wished this new practice plan to follow.

This proved to be a valuable indoctrination time during which I was able to evaluate the assistant's understanding of health and disease processes and his judgment. It also provided time to present to him my concept of family practice and of the ways in which an assistant could be most effective in service to patients.

### The Months that Followed

The trial period of the first three months was most successful and, in



my opinion, demonstrated the usefulness of a Physician Assistant for office practice in the medical health team. Acceptance by patients has been greater than expected. Certainly we have met with some resistance and objections from patients and doctors, but we have had a greater number of favorable and encouraging comments.

The assistant had most of his pre-practice training in medicine, especially cardiopulmonary problems, and in pre- and post-operative care. Emergency room experience as a corpsman in the Air Force had trained him for suturing and screening of injuries. Because of a paucity of training in obstetrics and gynecology and pediatrics, we plan future courses in these areas.

### **The Key**

Main areas in which the Physician Assistant's services have proved invaluable in freeing the physician for more serious medical problems became clearer as we gained more experience together. Routinely now the assistant takes the complete medical history and summarizes his impression to indicate where the physician should concentrate efforts in supplementing the history and physical diagnosis.

He screens nearly all the trauma cases which present to the office, such as those with injured wrists and ankles, and orders x-rays when indicated. Often I am presented with a history, a physical examination and an x-ray study regarding a fracture ready for definitive treatment. He also screens many illnesses during the day whenever the telephone receptionist is unclear as to the seriousness of the condition. Such screening greatly economizes the physician's time when it is necessary for him to evaluate a patient. I find that this approach eliminates much guesswork and many delays for the office staff and for the patient.

### **Unique Opportunity — A Real Test**

Through circumstances which led

my former medical associate to return for a residency nearly three months before his replacement could start practice, our physician-assistant association was put to a significant test. I am pleased to report the almost unbelievable ease of providing coverage for two practices. Certainly the daily task was not simple, and during that three months we did defer many examinations of well patients. However, the injured, the ill, and the worried well received expedient attention. Without an assistant the task of covering two practices would have been impossible, and yet with his help it was not only possible, but reasonably comfortable to accomplish.

### **A View into the Future**

Having a year of experience behind us and planning to add many more, I look at Physician Assistants not as the only solution to close the gap of medical manpower shortage but as an important one.

To expand upon this briefly, let us look at some Indiana figures which are similar to those of many other states. According to various projections Indiana needs about 6000 physicians to serve its population adequately. In December 1970, Indiana had about 4600 physicians supposedly providing patient care.<sup>1</sup> This does not reveal the total picture of health care delivery, considering that today only about half the total number of physicians will see patients in the "first echelon," that is, without special arrangement or referral. Thus, only about 2300 physicians are readily available to the general public. With a population of about five million people, Indiana is, as are many states, suffering from health care shortage.

Many groups in Indiana are concerned about the health care delivery system, and yet efforts to correct it appear to me to be doomed to failure unless altered. The excellent Indiana Plan will be of some help, but I do not see it as the total solution. Ac-

cording to the annual report from Dean Glenn W. Irwin at Indiana University Alumni Day, 1971, the plan will produce about 850 physicians in the next 12 years over and above the usual number of graduates. A new medical school started now in the state would do well to produce its first graduating class in 12 years. Not only will the 850 doctors fall short of the 1400 additional doctors needed in Indiana now (1971) but, with a projected population growth of 10 to 14% every 10 years, we can predict need for the addition of 600 to 800 doctors. Thus, in 10 years the increased doctor production of 850 will barely keep abreast with the population's increased needs and will not diminish the shortage at all.

Since part of the growing shortage can be attributed to longer training and longer delays in getting into practice due to residencies, one solution that has been suggested is to shorten training. I submit that we need these highly skilled, well trained men, but I also suggest that the short training of the Physician Assistant, with concentration on practical aspects of screening, affords the medical profession and the public relief from the shortages in health care delivery. It will do so more quickly than any other solution on the scene at present and can, with good university based training centers for Physician Assistants, do so while maintaining the present quality of care.

Our experience would suggest that a Physician Assistant screening for a physician can be expected to save the physician's time by as much as 40%. If this is reasonably accurate, then with Physician Assistant training programs in Indiana and recruitment of Physician Assistants to Indiana, health care delivery can be more efficient and, by saving doctors time, we might conceivably eliminate the manpower shortage in Indiana over the next 10 to 12 years.

In summary, our experience with the use of a Physician Assistant in

a private office during the past year has been excellent. During this year we have seen greater patient acceptance than any of us anticipated and have found that the Physician Assistant can effectively screen patients. We find patients are seen sooner in the course of their illness. If their problem is of a serious nature they

see the physician immediately. Having a Physician Assistant in the office has given the physician 40% to 50% more time to see patients needing his special skills. By increasing the doctor's productivity this appears to be a good method of reducing the medical manpower shortage.

REFERENCE

1. **Reference Data on the Profile of Medical Practice 1971**, p. 3; edited by D. E. Balfe, J. H. Lorant, C. Todd.

307 Medical Arts Bldg.  
Richmond 47374

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—May 1972

Disease	May 1972	Apr. 1972	Mar. 1972	May 1971	May 1970
Animal Bites	1277	859	855	1210	1477
Chickenpox	658	731	1047	357	471
Conjunctivitis	254	168	230	218	129
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	22	82	83	20	14
Gonorrhea	634	680	679	527	715
Impetigo	80	100	146	79	90
Infectious Hepatitis	53	41	62	68	80
Infectious Mononucleosis	126	131	162	115	121
Influenza	705	1164	4068	810	734
Measles					
Rubeola	219	180	181	720	53
Rubella	103	83	147	437	351
Meningococcic Meningitis	1	0	4	7	5
Meningitis, Other	1	3	1	6	3
Mumps	126	153	193	837	337
Pertussis (Whooping Cough)	79	12	7	9	17
Pneumonia	357	306	584	295	482
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1114	945	1630	724	844
Syphilis					
Primary & Secondary	14	28	19	28	35
All Other Syphilis	85	71	87	83	168
Tinea Capitis	2	2	5	0	1
Tuberculosis (Active)	57	70	73	99	76



# The Meaning of NAS/NRC Findings In Prescription Drug Advertising and Labeling

## I. Background

The Amendments of 1962 to the Federal Food, Drug and Cosmetic Act authorized the FDA to review available evidence of effectiveness on many drugs marketed between 1938 and 1962. Specifically, the Amendments provided that, after a two-year grace period, the effectiveness of such drugs should be supported by adequate and well-controlled clinical investigations. Until 1962, evidence on effectiveness had been considered in evaluating new drug applications only when it related to patient safety. Of course, long before 1962, the FDA had authority to remove any drug product from the market whenever it could prove that it would not perform as claimed or was deemed dangerous to health when used as directed.

In 1966, the FDA asked the National Academy of Sciences for assistance in assessing the evidence supporting the effectiveness of pre-1962 drugs. Consequently, and in cooperation with FDA and industry, the NAS/NRC appointed 30 six-man panels to review these drugs and frame recommendations to the Agency. Only evidence available through 1966 was considered. The panels conducted no research.

Panels rated each drug or drug claim as "effective," "probably effective," "possibly effective," "ineffective," "effective, but," or "ineffective as a fixed combination." These recommendations were transmitted to FDA by the NAS/NRC. Many drug products received mixed or indecisive evaluations. For example, some drugs were reviewed by more than one panel and received different recommendations from each. Drugs with several claims fre-

quently received varied ratings. It should be noted, too, that the consensus of a panel was not a recommendation of the NAS/NRC and, of course, had no legal effect.

FDA then considered the panel recommendations along with any other information at its disposal, and began regulatory action which has taken the form of: (1) a notice of effectiveness; (2) a request for change in labeling claims; (3) a request for more evidence, including clinical trials; (4) a request that the drug be reformulated; or (5) a proposal to remove the drug from the market. It should be emphasized that an initial notice in the *Federal Register* on implementation comprises only a first step in the process provided for in the Act for deciding a drug's effectiveness. Thus, much like a court case, there can be no presumption of a product's lack of effectiveness until all evidence is mustered.

FDA has now ordered that prescription drug labeling and advertising contain NAS/NRC panel findings other than "effective." This order becomes applicable only when an FDA implementation notice appears in the *Federal Register*. In those instances, when FDA disagrees with the NAS/NRC findings, the FDA finding will supersede and will appear instead of the panel finding. Thus, long before the issue of effectiveness is finally resolved, physicians will be informed of, and pharmaceutical manufacturers will be required to abide by, FDA's opinion.

It should be emphasized that FDA classifications of "less than effective" apply only to particular indications,

not to products *per se*, and will so appear in labeling and advertising.

The following statement delineating what the panels considered the classifications to mean are derived from the guidelines for the review published by the National Academy of Sciences, Division of Medical Sciences, and from the final report of the study published by the same group.

## II. The Findings

In the main, the findings relate to the availability (or lack of availability) of certain types of evidence rather than to the actual effectiveness of the drugs.

*"Effective"*—For the presented indication, the drug is effective on the basis stated.

*"Probably Effective"*—Effectiveness for the particular indication is probable but additional evidence is required before the drug can be finally assigned to the "effective" category. Modification of claims may be all that is needed. In some cases, the panels believe drugs in this category are effective on the basis of clinical experience but lack adequate and well-controlled studies.

*"Possibly Effective"*—There is insufficient evidence of effectiveness under the criteria listed for the study. However, in some cases here, as well as in the "probably effective" category, the panels believed the drugs to be effective on the basis of clinical experience. The panels were not always consistent with each other in the use of this and the "probably effective" rating.

*"Effective, But"*—Panels applied this rating to drugs for which there was substantial evidence of effective-

ness, but which they considered inferior to other drugs. This category is surprising since the Food and Drug Act does not permit the FDA to consider relative effectiveness in exercising its authority over drugs. It also was used to draw attention to so-called vaguely worded or misleading claims.

*“Ineffective as a Fixed Combination”*—This category does not involve effectiveness in its usual sense but rather reflects basic philosophical attitudes toward fixed combination products. Thus, the final report states that multiple therapy using fixed dose ratios, determined by the manufacturer and not by the physi-

cian, is, in general, poor practice. The findings “effective, but” and “ineffective as a fixed combination” are usually changed by FDA prior to publication to one of the other findings listed herein.

*“Ineffective”*—There is no acceptable evidence as to effectiveness.

### III. Conclusion

The service performed in general by the NAS/NRC review panels was outstanding and panel members and NAS/NRC staffers are to be commended for ably carrying out a complex task in a short period of time. However, because of the factors enumerated, each finding must be

considered individually. It should not be regarded necessarily as immutable doctrine but only as limited opinion on a question of drug therapy. Further, final decisions have not been made on many drugs. They remain available pending the development of further evidence.

Significantly, the panels themselves wrote as follows in the final report: “The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience.” ◀

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## Annual Meeting Dates of Professional Medical and Allied Organizations

### AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION

Date June 24-28, 1973  
Place New York

### INDIANA ACADEMY OF GENERAL PRACTICE

Date April 2-5, 1973  
Place Indianapolis Stouffer's Inn

### INDIANA DENTAL ASSOCIATION

Date May 14-18, 1973  
Place Indianapolis Convention/  
Exposition Center

### NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every month, September through June  
Place For location and program, inquire Jon Leipold, M.D., 919 E. Jefferson Blvd. South Bend 46622

### INDIANA PSYCHIATRIC SOCIETY

Date Second Wednesday of September, November, January, February, March and April  
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

### INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 14-18, 1972  
Place Indianapolis

### INDIANA SOCIETY OF INTERNAL MEDICINE and

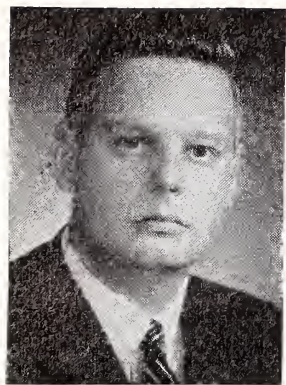
### AMERICAN COLLEGE OF PHYSICIANS COMBINED MEETING

Date October 18, 1972  
Place Indianapolis Convention/  
Exposition Center

### INDIANA CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

Date May 3-5, 1973  
Place Indianapolis, Hilton





## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THE Cost of Living Council recently announced that, henceforth, businesses which have 60 or fewer employees do not have to comply with the wage and price regulations under Phase II. However, there are some exceptions even to this exception. For example, doctors, hospitals, and building contractors are still covered by the controls, even though such businesses have fewer than 60 employees. Thus, it is going to be difficult to design the most favorable type of qualified retirement plans for such persons as doctors. Further, certain businesses which have annual sales of \$100 million or more and certain other businesses which have annual sales of \$50 to \$100 million are still within the controls.

Frequently, the I.R.S. claims that gifts of life insurance policies are made in contemplation of death—

obviously, because of the very nature of the property given away. However, in a recent case, the court found that such a gift to a trust (by a doctor) was not made in contemplation of death. While the court had several facts to support its view, one major consideration was that the donor-decedent did not need or want the cash surrender value of the policies. Further, he was most interested in having the cash surrender value available to the trustee in order to provide the donor's children with independent means. That is, the donor's lawyer had convinced the donor that the policies were safe and conservative investments which could be used for the support of the children or which could be sold by the trustee in order to invest the funds in other securities. If you are thinking about establishing an insurance trust, then you might ask your lawyer to send you a copy of this case—for fireside reading. See *Estate of Barton*, TC Memo 1972-30 (2/8/72).

Prentice-Hall (Englewood Cliffs, New Jersey) has just published an excellent estate planning check-list and fact gathering pamphlet. The cost of the booklet is nominal and it will be quite useful when you are having your lawyer plan your estate.

The I.R.S. has just issued a ruling that is significant to Indiana corporations. Under I.R.C. §1372, a newly incorporated corporation must elect to be treated under Subchapter S (of the 1954 Code) during the first month of the corporation's taxable year in order for such treatment to be effective for the first taxable year of the corporation. The new ruling states that if a state's law provides that a corporation's existence begins and that the subscribers to shares become shareholders on the day that the articles of incorporation

are filed, then the one-month period begins on the date that such articles are filed.

Indiana law provides that corporate existence begins and pre-incorporation subscribers become shareholders when the Secretary of State issues a certificate of incorporation. Thus, where an Indiana corporation has pre-incorporation subscribers, the one-month period begins on the day that the corporation's certificate of incorporation is issued. Presumably, if an Indiana corporation does not have pre-incorporation subscribers, then the one-month period begins on the day that the corporation receives payments for the issuance of the corporation's shares.

Incidentally, the one-month period means the period commencing with the beginning of the first day of the above-stated period and ending with the close of the day preceding the numerically corresponding day of the succeeding calendar month, or, if there is no such corresponding day, then with the close of the last day of such succeeding calendar month.

Another current I.R.S. ruling that will interest many businessmen is Rev. Rul. 72-192 (I.R.B. 1972-17). This ruling holds that membership fees or dues paid to the chamber of commerce by corporate employees are deductible under I.R.C. §162 as ordinary and necessary business expenses where the memberships in the chamber of commerce are used as a means of carrying out the substantive duties of the employee's employment. That is, in general, the I.R.S. will now allow a deduction for these dues and fees even if the employee isn't *required* to maintain the membership by the employee's employer. ◀



## ANGLO-AMERICAN CONFERENCE ON MEDICAL CARE

The Royal Society of Medicine, 1 Wimpole St., London W1M 8AE, 1971.

This soft-cover production of a symposium held in London, England, in April 1971 was sponsored by a tax-exempt organization called The Royal Society of Medicine Foundation, Inc. As far as I can judge, it is funded by grants from interested corporations such as Lilly International Corporation; Merck, Sharp and Dohme; Burroughs Wellcome & Co. (USA) Inc., and so on. The symposium is a complete survey of all the possible methods of producing and delivering medicine in the English speaking countries and especially regarding payments by the third party, whether government or insurance or both.

It consists of speeches by distinguished experts in such matters and includes, on the American side, Doctors Walter Bornemeier of AMA, John H. Knowles (of recent notoriety as the man from Harvard Medical who wasn't made Secretary of HEW) and, not least, Wilbur Cohen, former Secretary of HEW. The British speakers are counterparts whose names are perhaps not pertinent to a review in our journal. One name I must mention, though, is that of Enoch Powell, the well known British M.P. of ultra-conservative leanings.

There is much chaff among the grain, but I found myself getting an overview of this medical socialization situation which I certainly would not have otherwise. Included are large sections on Delivery of Care, Problems in Specialization and Training, and finally, The Consumer.

Some trends that can be enumerated:

1. The British National Health Service was a "grand" success for a homogeneous population such as England's but can't be transferred to America in the same form.
2. The G. P. seems to remain the underdog in the British system but he is getting organized in the Royal College of General Practitioners and through the British Medical Association.
3. The pluralistic approach is what is wanted in the USA and not an overall nationalization of medicine.
4. Mr. Powell, the right winger, spoke of "nil price, infinite demand." The gist of this is that if anything is completely free then there is no end of people wanting it—a word to the wise to Americans who are planning to completely alter the fee-for-service delivery of care by creating the so-called Health Maintenance Organizations (HMOs).

My final garnering from this book is that the consumer is soon to be a preponderant force regarding medical care delivery and payments in the USA. When this trend is realized, then we physicians had better be organized nationally and speak with one voice.

Read this symposium to get the complete picture of what is in store for us, my fellow Hoosier physicians! Forewarned is forearmed.

RODNEY A. MANNION, M.D.  
Michigan City

## CANCER DIAGNOSIS IN CHILDREN

L.D. Samuels, M.D., CRC Press, Cleveland. 131 pages with illustrations, 1972.

In the introduction to this book the author states that most physicians are unaware that cancer is the most common fatal disease in children. This book apparently is his attempt to educate physicians in the special techniques used to diagnose childhood cancer. It is emphasized that only by early diagnosis can the best opportunity for cure be obtained. He even suggests that parents be counseled to examine their children nightly, or at least weekly, for anything unusual and call this to the attention of their physician. One wonders what this emphasis on disease would have on both the parent and the child.

All diagnostic techniques are not given equal emphasis, probably as a result of the author's experience. Over one-half the book is on nuclear medicine. However, this is probably the area of diagnosis that most of us know the least about. This is discussed from the aspect of different isotopes used and also for the specific tumor suspected or region to be examined. This section is accompanied by many illustrations and seems to adequately cover this aspect of diagnosis.

The radiographic diagnosis of tumors in children is also emphasized and some special techniques are discussed. The single page given to anatomic pathology only briefly outlines the importance of the pathologist in cancer diagnosis in children. Most pathologists would feel that anatomic pathology plays a very important role in cancer diagnosis, possibly even as important as nuclear medicine. The surgeon fares only slightly better, getting three pages on surgical diagnosis. Therefore, possibly the general title of "Cancer Diagnosis in Children" is misleading. However, this book would be a useful addition to the library of any physician faced with the problem of diagnosing cancer in children.

ELTON HEATON, M.D.  
Madison

## MANAGEMENT OF JUVENILE DIABETES MELLITUS

Howard S. Traisman, M.D., C. V. Mosby Company, St. Louis, Second Edition, July 1971; 62 illustrations; \$19.75.

The preface of this book states that it was the author's purpose to provide a concise, practical method of management of juvenile diabetes mellitus for pediatricians and the general practitioner who may be infrequently called upon to diagnose and treat a child with diabetes. In addition, he hoped it would serve the needs of medical students, house officers and nurses.

Unfortunately, this monograph is a book as meager in content as it is in volume. The writing is uneven, with portions of the book being a scientific treatise while others represent reproductions of posters, graphs, tables and cookbook-style information.

The most impressive feature of this book is a nine-page chapter on the pathogenesis of diabetes mellitus contributed by Dr. Sheldon Berger of Northwestern University. The book simply does not stand favorable comparison with other more recent reference works, the most notable of which would be Volume III of the American Diabetes Association publication entitled "Diabetes Mellitus: Diagnosis and Treatment," which provides 61 chapters of practical and authoritative information on all aspects of diabetes—all for \$4.75.

STEVEN C. BEERING, M.D.  
Indianapolis



## ADVANCES IN FORENSIC AND CLINICAL TOXICOLOGY

A. S. Curry, C. R. C. Press (Division of Chemical Rubber Co.), Cleveland, 1972; 280 pages; \$32.50.

Dr. Curry, of the Central Research Establishment of England's Home Office, has written a review of the more recent literature over a wide area of toxicology. In 194 pages he mentions 1493 references, most of which are from the years 1966 to 1971.

The volume is directed towards the laboratory worker and there is little here to interest the clinician. Analytical chemists will find an outline guide to recent methodology. This is not to say that the book is a "cookbook." The original articles or books will have to be consulted for details. The clinical pathologist will enjoy browsing through the volume, although he will not expect to find material of immediate practical importance. For the forensic pathologist, the first chapter, which is on carbon monoxide, is outstanding.

JAMES ROSS MACKENZIE, M.D.  
Indianapolis

## PREVENTIVE MEDICINE IN WORLD WAR II, Vol. IX

Edited by Lt. Gen. L. D. Heaton, Office of the Surgeon General, Department of the Army, Special Fields, Washington, D.C., 603 pages, illustrated; \$8.00.

This book represents the ninth volume in a series of books on preventive medicine in World War II published by the Office of the Surgeon General, United States Army.

It deals with a number of diverse problems in the field of preventive medicine which were not covered in the preceding books in this series. Included are chapters concerning training of preventive medicine officers and personnel. Particular emphasis in this area is centered on training in tropical medicine. Also included are chapters on occupational health and industrial medicine.

Special emphasis is also placed on environmental and climatic factors, particularly heat trauma and cold injury. There is a chapter covering the handling of enemy prisoners of war and the problems this presented to the Medical Corps with reference to proper sanitation and disease control.

Approximately one-third of the book is devoted to a review of medical laboratories of all types and in all geographic areas. Particularly interesting is the section dealing with the hospitals in combat zones and also the organization tables for a general medical laboratory as it functioned during the war.

This 603-page volume is well illustrated with tables, charts and photographs. The index is comprehensive and well cross referenced. It would be of particular value to those interested in medical military history. Pathologists and physicians interested in preventive disease would also find it entertaining reading.

DOUGLAS A. TRIPLETT, M.D.  
Muncie

## TEXTBOOK OF MEDICINE

Beeson and McDermott, 13th Edition of Cecil-Loeb. Saunders Co., 1972; 1923 pages with numerous illustrations and tables.

When I reviewed the 12th edition of this textbook (JISMA, Oct. 1967, p. 1439) I commented on the fact of it being THE leader in its field. The present revision only lends added emphasis to the observation.

While it is hard to pick on any single new author or completely rewritten chapter, several items did attract me for careful second reading. Thus, the chapter on leprosy by Dr. Arnold has

been updated while still being crisp, concise and wholly authoritative. On page 671, the chapter on "Bejel" is in the same category. On p. 747, I stumbled on the statement that "100,000 Puerto Ricans living in NYC alone carry schistosomiasis. . . ." How truly fortunate we are that the susceptible snails are NOT present in the immediate environment! On page 834, Dr. Beeson enlightened me on an entity new to me: "Lethal, midline granuloma, a *horrid*, rare destructive disease . . . nearly always terminating in death."

Dr. Fishman has a most instructive, updated discussion (page 946 and on) on heart failure, its pathophysiology, course and therapy. Whether a student or a professor of cardiology, you'll find it thought provoking. Dr. Kowlessar (page 1312 and on) has a magnificent chapter on pancreatic disease. To me, the discussion on the therapy of necrotizing and hemorrhagic pancreatitis was most apropos. But why go on and on?

The binding and typo-free printing are of the usual quality. This volume is a must for every medico's shelf right above his desk—available for immediate access when a particular topic needs clarification.

ARNOLD LIEBERMAN, M.D.  
New York

## ONE LIFE

Christiaan Barnard and Curtis Bill Pepper, Bantam Books, Inc., New York, N.Y., 1971.

Some famous men await their declining years to recount the agony and glory that was their lives but in this day of increasing speed I suppose it is expected that the autobiographical syndrome will erupt with an attenuated prodrome. So it is with Christiaan Barnard whose natal year was 1922. We know that this man of Capetown, South Africa, was the first surgeon to transplant a human heart, but there exists no such general knowledge of the tortured and compulsive human being behind the headlines. This "autobiography" paints an almost alarming portrait of a driven but doing and succeeding personality. That the narrative is possibly more of Curtis Bill Pepper, the so-called "second author," detracts but little from the impact of Barnard's character.

The book traces his life from an impoverished childhood in rural South Africa (near a semi-desert called the Great Karoo), through his medical school days at Capetown and subsequently at Minneapolis, Minn., where he trained under the American surgeon Wangenstein. He earned his Ph.D., in surgery in just two years of study and work.

His father was a white minister to a "colored" congregation and was greatly loved by young Christiaan, but the boy took much of his push from his mother. His predominant emotion towards the mother would seem to be admiration. Chapter III chronicles his failure to adjust to an associateship with an older, small town general practitioner. Of course, he felt superior to this man and probably was, but much is made of the fact that Barnard's name was in third place on the brass plate. His mother, however, always demanded that he be first as a child. It is thus that the author (be he Barnard or Curtis Bill Pepper) creates dramatic tension. Only it is laid on thickly and becomes more than occasionally lacrimal. Is it possible for a man (hero, that is) to be simultaneously altruistic, lashed forward by a fearful ego and also excessively sentimental? So it would seem.

My sense of the reality of his life improved while reading the later chapters. As he progresses towards his rendezvous with fate as the premier heart transplant surgeon, I detected, as a doctor and surgeon myself, more of the true substance of all our lives in medicine. I found his years of training in America absorbing and was enthralled with the description of the preoperative and postoperative treatment of Louis Washkansky, the first cardiac

transplant patient. I excuse the fact that there is an overabundance of detail for the novelistic form.

My overall feeling upon reading the book was gratitude for my own life as a physician. Much of the essence of medicine is here and I find that I admire Christiaan Barnard. He must make his friends and relatives impatient with him though.

Read this book, it is worth the effort.

RODNEY A. MANNION, M.D.  
Michigan City

## PERIPHERAL VASCULAR DISEASES

Fourth edition, 1972; originally projected by Dr. Geo. E. Brown—First Edition (1946)—Allen, Barker & Hines—presently completely revised by Drs. Fairbairn, Juergens and Spittel—Saunders & Co., 797 pages with numerous color and black and white illustrations.

This Mayo Clinic continuing effort in a challenging area of endeavor is making the present revision a real classic. As I hold in my hand the well-worn copy of the *first* edition, I can only marvel at the colossal progress that has been made in the quarter century since the end of World War II.

The continuation of the dozen-odd pages inserted in the text bearing the photos and brief biographies of leaders in the field is a pleasant change of pace, also, quite instructive. I liked particularly the splendid discussion on lymphedema and such odd variants as "lymphedema praecox." Other varieties of it are presented and superbly illustrated. The discussions on the surgical orthopedic procedures are outstanding; a complex topic made almost simple.

The profuse colored photos are not to be faulted; the x-rays help the text; the paper, binding and printing are first class. I saw no typo errors. All in all: The Mayo Group deserves all kudos imaginable. Congratulations.

ARNOLD LIEBERMAN, M.D.  
New York

## Abstracts From Various Literature, Prepared by AMA

### SURGICAL TREATMENT OF IMPENDING MYOCARDIAL INFARCTION

G. M. FitzGibbon and G. D. Hopper (National Defense Medical Center, Ottawa)

*Can. Med. Assoc. J.* 106:323-326 (Feb. 19) 1972.

Two men, ages 29 and 44 years, presented with clinical and ECG evidence suggesting impending myocardial infarction. Selective coronary angiography revealed serious obstructive coronary atherosclerosis including gross stenosis of the main left coronary artery in both. Emergency surgical operations were performed, a double aorto-coronary venous bypass in one and a single venous bypass combined with a Vineberg operation in the other. Neither patient sustained myocardial infarction and both are well more than six months after operation.

### SOME ANTIINFLAMMATORY PROPERTIES OF ASCORBIC ACID

F. A. Dolbeare and K. A. Martlage (Eli Lilly Co., Indianapolis 46202)

*Proc. Soc. Exp. Biol. Med.* 139:540-543 (Feb.) 1972.

Ascorbic acid was compared with aspirin and phenylbutazone for inhibitory action against lysosomal *b*-glucuronidase, ultraviolet

erythema, carrageenan edema, adjuvant arthritis and peritonitis-polyarthritis. The vitamin was a very effective inhibitor of *b*-glucuronidase activity and peritonitis-polyarthritis swelling, but a moderately effective inhibitor of adjuvant arthritis swelling. Ascorbic acid was weakly inhibitory in the carrageenan edema, and not inhibitory against ultraviolet erythema.

### SPONTANEOUS REGRESSION OF HEPATIC METASTASES FROM GASTRIC CARCINOMA

S. A. Rosenberg et al. (Immunology Branch, National Cancer Institute, Bethesda, Md. 20014)

*Cancer* 29:472-474 (Feb.) 1972.

A patient with gastric carcinoma had hepatic metastases proved by biopsy. He survived for 12 years in the absence of therapy, at which time laparotomy revealed total regression of the tumor tissue in the liver.

### BENIGN BREAST DISEASE IN WOMEN ON ESTROGEN THERAPY

R. E. Fechner (Baylor College of Medicine, Houston 77025)

*Cancer* 29:273-279 (Feb.) 1972.

Breast tissue was examined from 43 women taking estrogens for menopausal symptoms or postmenopausal replacement therapy. Two of the patients had typical fibro-adenomas. Tissue from the remaining patients presented the spectrum of fibrocystic disease. The patients taking estrogens had a slightly greater frequency of epithelial hyperplasia (39%) compared to the controls (32%). No qualitative differences were detected between the two groups and the slight variation in frequency of hyperplasia is judged to be insignificant.

### TREATMENT OF BLEEDING ESOPHAGEAL VARICES WITH LINTON-NACHLAS TUBE

D. Brunswig and H. Liehr (Medizinische Universitätsklinik Würzburg, West Germany)

*Dtsch. Med. Wochenschr* 97:502-507 (March 31) 1972

The single-ballooned, triple-lumen tube described by Linton and Nachlas was successfully used in five patients with bleeding esophageal varices for a total of 25 times. The Linton-Nachlas tube has important advantages over the usual double-ballooned tube of Sengstaken-Blakemore in that compression of the fundus and cardia of the stomach, as well as the lower third of the esophagus, produces a reliable cessation of bleeding even in cases with fundus varices, and it permits differentiation between bleeding from esophageal varices and from gastric or duodenal ulceration.

### ANTIHIJACKING EFFORTS AND CARDIAC PACEMAKERS

O. C. Hood et al. (Federal Aviation Administration, Washington, D.C. 20590)

*Aerosp. Med.* 43:314-322 (March) 1972.

Fifty-three patients with permanently implanted pacemakers were exposed to the active magnetometer field. No patient was aware of any symptoms on passing through the detector, no pacer ceased to function while in the magnetometer field, post-test ECGs showed no change in rate in any pacemaker, no patient suffered ill effects from the test, and no standard ventricular unipolar or bipolar pacemaker was affected by the weapons detector used in the study. ◀



# Your Blue Shield Professional Relations Staff

THE Indiana Blue Shield Professional Relations External staff has been expanded and is providing greater service to physicians of Indiana and their medical assistants by solving problems and furnishing information with regard to Blue Shield.

Ten persons who comprise the External staff are part of a total of 32 people in the department, contrasted with only two men and one secretary on the staff four years ago. Assisting the head of the staff is a manager and seven field representatives.

The Professional Relations staff provides educational services by informing physicians and their office staffs about Blue Shield and through distribution of a doctor's assistant's handbook.

The staff also handles inquiries from physicians, such as claim problems, and explains and adjudicates usual and customary programs and utilization review.

Other parts of the program include conducting miscellaneous investigations, attending various meetings, conventions and seminars, as well as furnishing any other form of assistance needed.

Every field representative not only possesses a complete knowledge of Blue Shield information, but is involved with all physician activities relating to health care.

Each representative makes an average of 20 contacts with physicians per work day. The data gathered from each visit is recorded by a new computerized system implemented by Professional Relations in February, 1972. Formerly, physician data was recorded manually. In contrast, the new system saves time and allows a more complete listing of standardized information to be filed for quick access by the Representatives.

Those who normally call long distance to Blue Shield Professional Relations may use the WATS line number, 800-382-1600, at no charge. Local callers in the Indianapolis metropolitan area should dial 263-4764.

Heading the Professional Relations staff is Herbert P. Dixon, vice president, who has been with Blue Shield for eight years. Mr. Dixon attended Wabash College and is a Butler University graduate with an A.B. in political science and an M.S. in administration. He was recently elected to the board of trustees of the Butler Alumni Association.

Manager in charge of Representatives who work directly with physicians and their offices is Gary R. Miller, who has been with Blue Shield for four and one-half years. He is a graduate of Butler University with a B.S. degree in radio and television and was a corpsman in the Army Reserve. He is a member of the Indiana Public Health Association Board of Directors.



H. P. Dixon  
Vice President



G. R. Miller  
Manager

Mr. Dixon and Mr. Miller normally handle departmental planning medical society meetings, district society meetings, hospital staff meetings, Blue Shield seminars and district advisory council meetings.

The field staff includes two Representatives who cover the entire state, specializing in government contract work, plus five Representatives who service a specific area.

Jack Byrne, a registered pharmacist, calls on pharmacists and dentists and allied professions throughout Indiana. He owned and operated a drug store in Greenfield for 18 years prior to joining Blue Shield. In addition to his field duties, he presents a series of Blue Shield lectures to fifth year students in the pharmacy school at Purdue.

Jerry Waid, formerly a supervisor in Medicaid, meets with optometrists, medical supply dealers, ambulance providers and dentists in his work throughout the state. Mr. Waid also lectures to optometry students at Indiana University. He attended Indiana Central College.

Phil Sizelove is assigned the northwest Indiana region. He is a Ball State University graduate and majored in business administration. He was a corpsman in the Army Reserve.

Jerry Martin, who has been with Blue Shield for two years, covers the northeastern Indiana territory. He is a Navy veteran and a graduate of Indiana University with a B.A. in chemistry.

Beverly McGraw, a registered nurse and the first woman Field Representative, has the central Indiana district plus extensive activity with medical assistants and their state organizations. She is a graduate of Ball State and worked in a doctor's office for 21 years.

Tom Erwin calls on southwestern Indiana physicians. A Navy veteran, he was a manager in Medicare for two years before joining Professional Relations. He has lectured at the Bryman School for Medical Assistants in Indianapolis and MA classes at Ivy Tech, along with Manager Gary Miller.

Steve Tope, the newest Representative, serves physicians in southeastern Indiana. He is a graduate of Edgewater Hospital School of x-ray technology and has x-ray technology experience at St. Vincents and Winona Memorial Hospitals in Indianapolis. He was a corpsman in the Army Reserve and holds a B.S. degree in Business Administration from Indiana University.

Comprising the secretarial staff for Professional Relations are Mrs. Linda Huber, secretary to Mr. Dixon; Mrs. Mary Wagner, secretary to Mr. Miller; and Mrs. Debbie Eddy, field secretary.



# FIELD REPRESENTATIVES

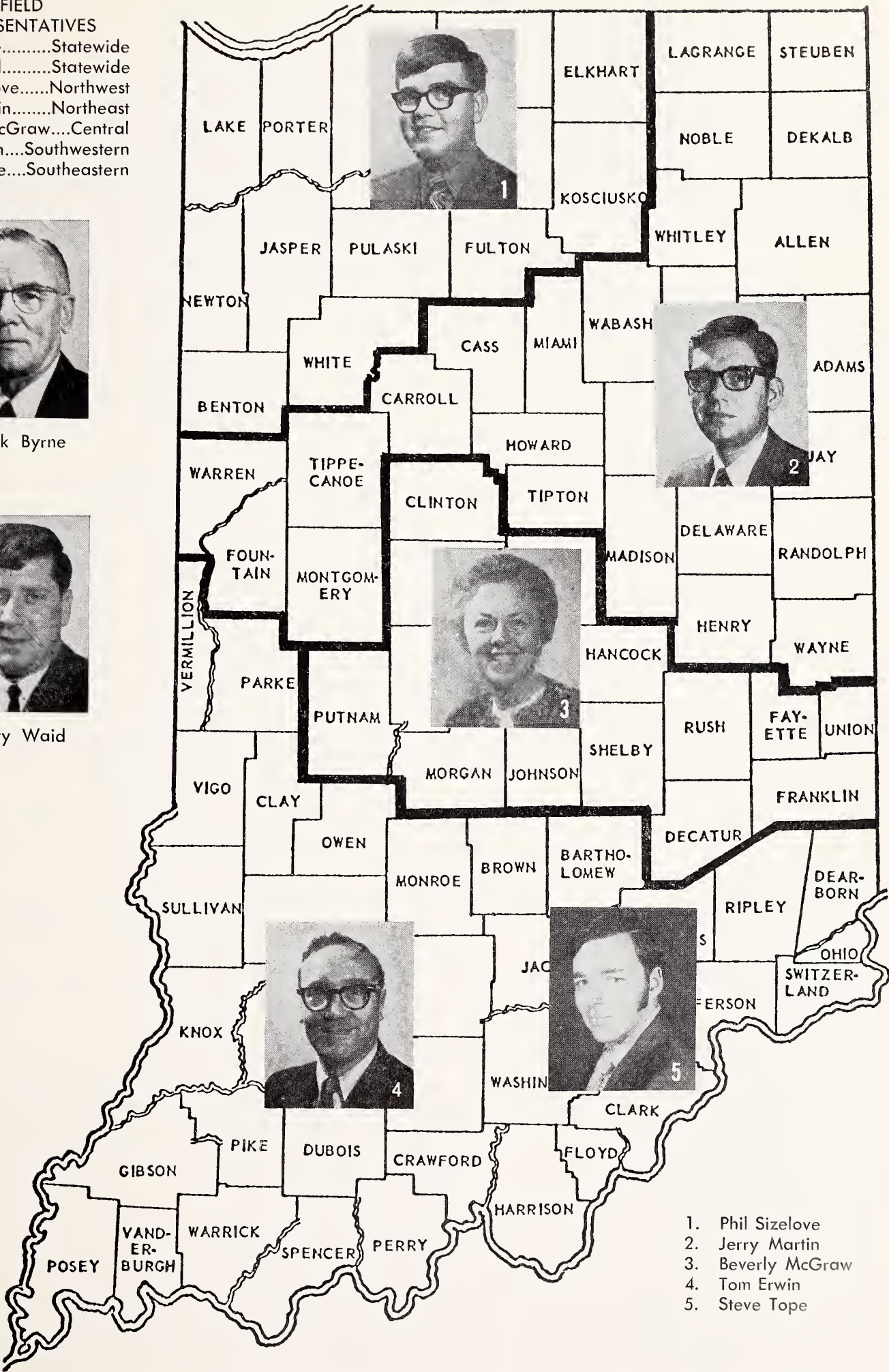
Jack Byrne.....Statewide  
 Jerry Waid.....Statewide  
 Phil Sizelove.....Northwest  
 Jerry Martin.....Northeast  
 Beverly McGraw....Central  
 Tom Erwin....Southwestern  
 Steve Tope....Southeastern



Jack Byrne



Jerry Waid



1. Phil Sizelove
2. Jerry Martin
3. Beverly McGraw
4. Tom Erwin
5. Steve Tope



## FUTURE MEETINGS, SEMINARS, COURSES

### **Denver to Host Cancer Conference**

The Rocky Mountain Cancer Conference will meet at the Brown Palace Hotel, Denver, on July 21 and 22. There is no registration fee. New information on cancer will be presented. The meeting is approved for AAGP credit. Hotel reservations may be sent direct to the hotel, 17th and Tremont Place, Denver 80202.

### **First International Symposium On Emergency Medical Services Set**

The First International Symposium on Emergency Medical Services will be conducted in Honolulu July 31 to August 4. For details write ISEMS Coordinator, % Trade Winds Tours of Hawaii, P.O. Box 2198, Honolulu, 96813.

### **Academy of Orthopaedic Surgeons Offers Courses on Emergency Care**

The Committee on Injuries of the American Academy of Orthopaedic Surgeons has scheduled courses on emergency care at 11 locations around the country. Five have already been conducted. The remaining courses are offered on the dates and at the places listed: Washington, D.C., Aug. 16-19; Madison, Wis., Aug. 28-Sept. 1; Little Rock, Ark., Sept. 13-16; San Francisco, Sept. 14-16; New York, Oct. 12-14; and St. Louis, Nov. 26-29.

The courses are for ambulance, civil defense, industrial safety and public health personnel; emergency medical technicians, emergency squads, volunteer rescue squads, firemen, policemen, safety engineers and nurses. Advanced first aid training is a prerequisite for the course. Tuition is \$50.

Further information may be obtained from the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago 60611; telephone 312-822-0970.

### **Orthopaedic Surgeons to Offer Basic Science Course at Fort Wayne**

The American Academy of Orthopaedic Surgeons will sponsor a postgraduate course on basic science August 23 to 26 in Fort Wayne. The course chairman is Dr. Frederic W. Brown. Topics covered will include anatomy, metallurgy, genetics, and polymerization and physical properties of cements in total hip replacement. For application forms and information write Dr. Brown at 2609 Fairfield Ave., Fort Wayne 46807.

### **Schedule Conference On Cancer Chemotherapy**

The 10th Cancer Chemotherapy Conference will be held at the University of Wisconsin in Madison September 6 to 8, at the Park Motor Inn. It is open to all physicians interested in cancer chemotherapy. It will consider anti-cancer therapy of solid tumors and leukemias as well as the role of radiotherapy, immunology and virology. For full details write G. Ramirez, M.D., 714-C University Hospitals, 1300 University Ave., Madison, Wis. 53706.

### **Clinical Gastroenterology PG Course Scheduled for Bermuda in September**

The American Society of Gastrointestinal Endoscopy will hold a postgraduate course on Clinical Gastroenterology at the Castle Harbour Hotel in Bermuda September 10 to 16. The fee for non-members is \$150, for residents or fellows \$75. Write Dr. Vernon M. Smith, 301 St. Paul Place, Baltimore 21202.

### **16 Postgraduate Courses Included in ACS Clinical Congress in October**

All doctors of medicine are welcome to attend the Clinical Congress of the American College of Surgeons to be conducted October 2 to 6 at San Francisco. Registration fee for non-Fellows is \$90, doctors in Federal service pay \$50, surgical residents register free. There will be 16 Postgraduate Courses for which moderate fees are charged. Official forms for registration, housing and postgraduate courses will be available after June 1. Write S. Frank Arado, American College of Surgeons, 55 E. Erie St., Chicago 60611.

### **Otolaryngologic Assembly To Be Held in October**

The annual Otolaryngologic Assembly of 1972 will be held October 14 through 20, 1972, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, M.D. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to the mailing address: OTOLARYNGOLOGY, P.O. Box 6998, Chicago, Ill. 60680.

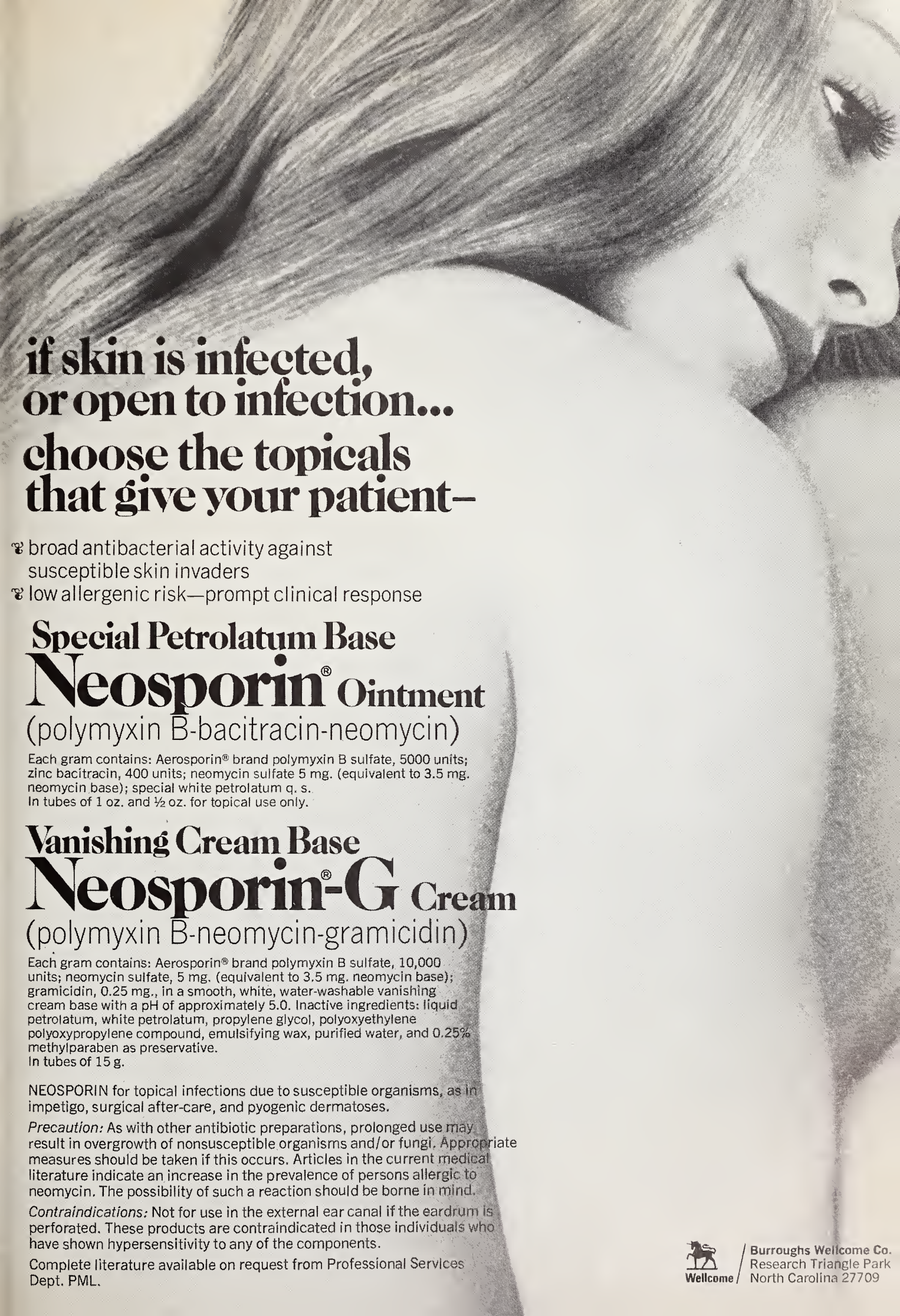
### **Louisville Sets Symposium On Infections in the Newborn**

The Sixth Annual Newborn Symposium on Infections in the Newborn will be conducted by the Department of Pediatrics of the University of Louisville School of Medicine in the Health Sciences Center Auditorium in Louisville on November 2 and 3. For information write to Dr. Billy F. Andrews, 226 E. Chestnut St., Louisville 40202.

### **Scientific Assembly Set for Nov. 13-16**

The Interstate Postgraduate Medical Association announces its Scientific Assembly to be held at the Washington-Hilton Hotel, Washington, D.C., November 13 to 16. Complete details may be obtained by writing Roy T. Ragatz, P.O. Box 5445, Madison, Wis. 53705. ◀





**if skin is infected,  
or open to infection...  
choose the topicals  
that give your patient—**

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

**Vanishing Cream Base**  
**Neosporin<sup>®</sup>-G Cream**  
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.  
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

**Precaution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709





## When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

### **1.2 to 8 grams/day IV dosage range:**

Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections.

In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

### **Effective gram-positive antibiotic:**

Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone





infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

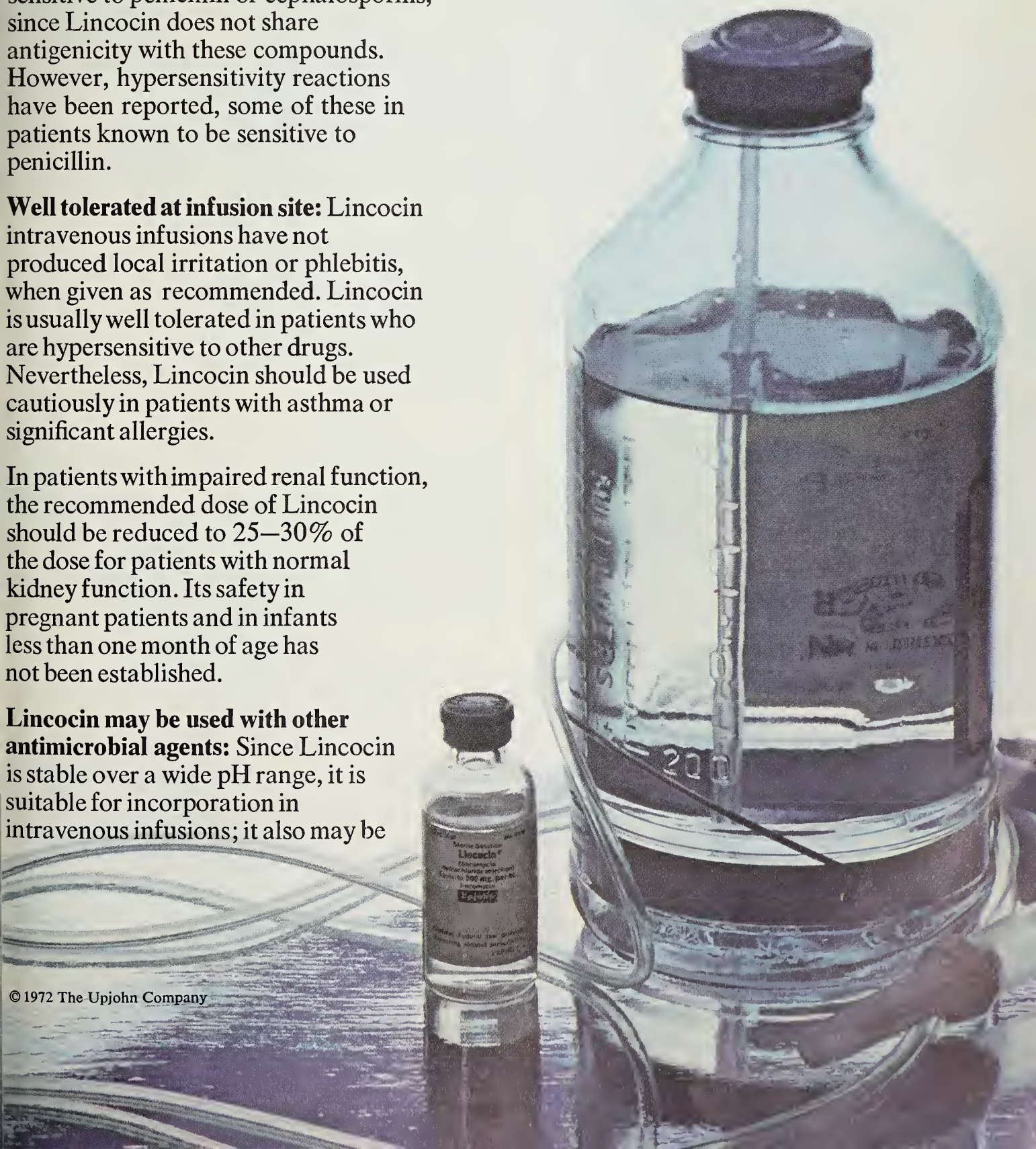
**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

**Lincocin<sup>®</sup>**  
Sterile Solution (300 mg per ml)  
(lincomycin hydrochloride, Upjohn)  
For further prescribing information, please see following page.







Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

## (lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections.

Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:

Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg Pediatric Capsule ..... 250 mg  
500 mg Capsule ..... 500 mg  
\*Sterile Solution per 1 ml ..... 300 mg  
Syrup per 5 ml ..... 250 mg

\*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg and 500 mg Capsules—bottles of 24 and 100. Sterile Solution, 300 mg per ml—2 and 10 ml vials and 2 ml syringe. Syrup, 250 mg per 5 ml—60 ml and pint bottles.

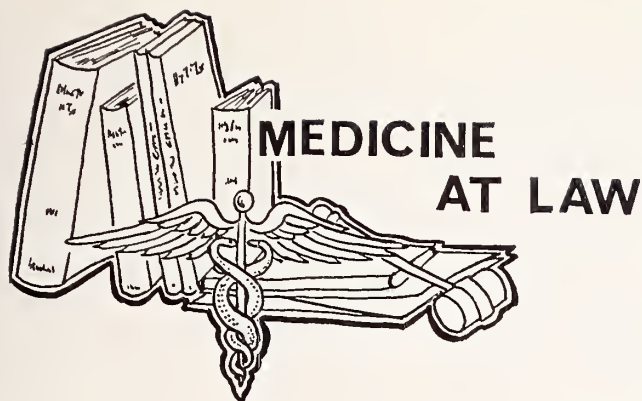
For additional product information, consult the package insert or see your Upjohn representative.

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**Upjohn**





**Fatal Liver Damage Caused by Anesthetic**—The family of a patient who died of liver damage after receiving halothane anesthesia in two separate operations was awarded \$150,000. The award, handed down by a California jury, was against the surgeon only, and not against the anesthesiologist.

The patient, a 45-year-old housewife, underwent an elective hysterectomy, at which time she received halothane anesthesia. She was discharged from the hospital after about nine days and was readmitted two days later with a temperature of 105 degrees. She was very ill, having nausea, lack of appetite, and dark and concentrated urine.

A second operation was performed to arrest vaginal bleeding. The surgeon and anesthesiologist were the same as for the previous operation, and halothane anesthesia was again used. The patient died two days later because of massive liver damage.

The woman's husband and four minor children brought action against the surgeon, the anesthesiologist, the hospital, and the manufacturer of halothane. They contended that there had been reports that halothane had caused massive liver damage in some patients and should not be given a second time when there is evidence of active liver damage or disease.

The family said that the patient had evidence of liver damage after receiving halothane the first time and should not have received it again.

Although there had been no evidence of jaundice before the second operation, they contended that there had been signs and symptoms consistent with liver damage. Further, they said that the surgeon should have made a diagnosis of liver damage before the second operation and called in a specialist.

The anesthesiologist testified that if he had known of the liver damage he would not have given the patient halothane a second time. It was contended that the cause of death was infectious hepatitis and that it was in the incubation stage before the patient was admitted to the hospital for the first operation.

It was also contended that there could not have been liver damage by the time of the second operation without evidence of jaundice. The patient's family said that if a liver function test had been done before the second operation it would have disclosed liver damage.—*Ganczewski v. Smith* (Cal. Super. Ct., Ventura Co., Docket No. 52055, 1971).

**Hospital's Liability for Negligent Appointment of Staff Physician**—A hospital is liable for injuries to a patient by an unskilled staff physician if the hospital negligently failed to exercise care in determining his professional competence, a Georgia appellate court ruled. Since the pretrial affidavits filed by the physician, the hospital and the patient were in conflict as to the treat-

ment rendered by the physician, the court ruled that the case against the physician, as well as the case against the hospital, must be submitted to a jury.

A woman had brought her husband to the hospital at 11 p.m. because of his chest pains. The woman claimed that the physician examined him and said that his condition was not serious. She further claimed that the physician gave her husband a prescription and sent him home.

At home, the man continued to suffer severe chest pains. One and one-half hours after they arrived home, they started to return to the hospital. The man died before they reached the hospital.

The wife filed a lawsuit against the physician and the county agency which operated the hospital. She contended that the physician was negligent in failing to make an adequate and proper examination and in failing to admit her husband to the hospital for more extensive examination, diagnosis and treatment.

She also contended that the hospital was negligent in failing to exercise care in determining the physician's professional competence and moral character and in failing to make any investigation into his qualifications, character or background.

The physician and the hospital denied any negligence. The hospital claimed that the responsibility for screening candidates for staff privileges had been delegated to members of the medical staff. The hospital administrator filed an affidavit stating that a staff physician's diagnosis and treatment of patients are matters left to the physician's sole discretion.

The physician claimed that he had made a proper examination and had rendered proper treatment. He said that he had advised the man that he should be admitted to the hospital. The physician claimed that the man rejected this advice. The man's widow denied these statements.

On the basis of affidavits contain-



ing these conflicting statements, the trial court entered summary judgment in favor of the hospital and the physician. The widow appealed.

The summary judgment was reversed by the appellate court. The court noted that a hospital has a duty to act in good faith and with reasonable care in admitting physicians to staff privileges. The mere fact that the physician is a licensed physician does not fulfill this duty, the court held.

A state statute authorized hospitals to delegate the screening of candidates for staff privileges to existing members of the medical staff. However, the court ruled that such members of the medical staff act as agents for the hospital in the screening process. Therefore, the hospital was liable for any default or negligence committed by these staff members, the reviewing court ruled. The case against the hospital was remanded for trial to determine whether the physician was unskilled and whether the hospital was negligent in granting him staff privileges.

The case against the physician was also remanded for trial. The court ruled that, since the affidavits were in conflict as to what actually happened, the matter should be resolved at trial.—*Joiner v. Mitchell County Hospital Authority*, 186 S.E. 2d 307 (Ga. Ct. of App., Oct. 8, 1971; rehearing denied, Nov. 16, 1971; cert. denied, Ga. Sup. Ct., Jan. 19, 1972).

**Hospital Fails to Take Timely Blood Cultures**—Where evidence was tenuous that a hospital's failure to take timely blood cultures was a contributing factor in a patient's subsequent illness, a New York appellate court granted a new trial to give the patient an opportunity to introduce further evidence.

The patient brought action against a physician and the hospital, contending that she suffered infections and abscesses as a result of the hospital's failure to take timely blood cultures. Her only evidence was

testimony by a physician that, if such cultures had been taken and the infecting organisms identified, then the patient could have received proper treatment with antibiotics. Such treatment might have contained the infection, he stated, and pelvic abscesses might not have developed.

The hospital contended that the blood cultures eventually taken were negative and that antibiotics would not have affected the initial abscess after it had formed. The hospital said if such cultures had shown organisms, the patient's treatment would not have been different from that which she received before formation of the initial abscess.

The jury brought in a verdict for the patient. The trial court set aside the verdict against the hospital and dismissed the complaint.

On appeal, the court held that the verdict against the physician was supported by the weight of evidence. The court further said that setting aside the verdict against the hospital was warranted but the trial court should have granted a new trial and not dismissed the complaint.

Holding that the evidence was too tenuous and sparse to establish that the hospital's failure to take timely blood cultures had contributed to the seriousness of the patient's illness, the court granted a new trial to afford the patient further opportunity to introduce evidence of a causal relation between the hospital's failure and her subsequent illness.—*Kuper-smith v. Vosburgh*, 328 N.Y.S. 2d 300 (N.Y. Sup. Ct., App. Div., Dec. 6, 1971).

**Chiropractor's Conviction for Murder Upheld**—A chiropractor convicted of second-degree murder after the death of a patient he had treated for cancer was denied a writ of habeas corpus by a federal appellate court. The court held that the chiropractor was not placed in double jeopardy when he was tried and convicted a second time for the same offense.

The chiropractor convinced the parents of an 11-year-old girl that he could cure the child's cancer without surgery. Prior to consulting the chiropractor, the parents had agreed to an operation for removal of the child's eye because of a fast-developing cancerous growth, diagnosed on biopsy. The chiropractor told the parents that a biopsy was not necessary because a machine existed that could detect cancer. He said that if you cut into a cancer it would merely spread to other parts of the body.—*Phillips v. Pitchess*, 451 F. 2d 913 (C. A. 9, Nov. 10, 1971; rehearing denied, Dec. 20, 1971).

**Deductibility of Special School Expenses**—The deductibility of the cost of attending special schools has been the subject of recent tax rulings.

In one case, a boy suffered from recurring epileptic seizures. He was enrolled in a private school for college-preparatory education. The school had no medical facilities. It was not regularly engaged in providing medical services. The boy's physician had not recommended any special type of school.

The taxpayer claimed that the tuition for the school was a deductible medical expense. She argued that the school's regime was necessary to alleviate her son's condition.

The deduction was disallowed by the United States Tax Court. The court ruled that the school's educational program did not constitute medical care and that the expense was not primarily for medical care.—*Shidler v. Commissioner*, T. C. Memo. 1971-126 (May 27, 1971).

In another case, a taxpayer had placed his son in a school for mentally retarded children. In addition to teachers, aides and household personnel, the school was staffed by a speech therapist, a psychologist and a registered nurse. The boy's physician had recommended that he attend the school. The primary purpose

of attending the school was to alleviate the boy's handicap. The State paid a portion of the tuition, room and board for the boy.

The portion of the tuition, room and board paid by the taxpayer is deductible as a medical expense, the Internal Revenue Service ruled. It also ruled that the portion paid by the State would not be considered in determining whether the taxpayer contributed more than 50% to his son's support for purposes of claiming him as a dependent.—*IRS Rev. Rul. 71-347*, I.R.B. 1971-31, 13.

**Judgment for Patient Reversed in Bone Implantation Case**—A patient who sues a drug manufacturer for negligence and breach of implied warranty must show that the product in question was defective, according to a Florida appellate court.

A patient suffered a spinal injury during the course of her employment. Her physician determined that she needed corrective surgery, consisting of a spinal fusion at three levels. A piece of bone from an outside source is sometimes employed in this type of surgery. In this case, a piece of beef bone processed and sold under the trade name of "Bo-plant" was employed.

Some time after the surgery was performed, x-rays indicated that a portion of the beef bone had been absorbed by the patient's body. Exploratory surgery revealed inflamed reactive tissue at the "Bo-plant" site. The "Bo-plant" was removed. The patient brought suit against the drug manufacturer for damages she suffered as the result of the operation.

In reversing judgment for the patient, the appellate court held that, to hold the drug manufacturer liable, a defect in the "Bo-plant" used must be shown. The court noted that whether suit is brought for negligence, breach of warranty or strict liability, the patient's injury must have been caused by some defect in the product. In this case, there was

no evidence that the "Bo-plant" used was defective.—*E. R. Squibb & Sons, Inc. v. Jordan*, 254 So. 2d 17 (Fla. Dist. Ct. of App., Nov. 2, 1971; rehearing denied, Nov. 19, 1971).

**Covenant not to Compete Upheld**—A physician may sue to enforce the liquidated damages provisions of a covenant not to compete, according to the Wisconsin Supreme Court.

Two physicians entered into an agreement providing that the older physician would employ the younger one for six months. At the end of that period, they were to enter into a partnership. If the younger physician refused to become a partner and entered into competitive practice, he agreed to pay the older physician a specified sum as damages.

At the end of his six months' employment, the younger physician refused to enter into a partnership. He then set up his own practice in competition with his former employer.

The older physician immediately brought suit for the damages provided under their agreement. The suit was challenged on the grounds that the complaint was insufficient in law to state a cause of action.

In affirming the decision for the older physician, the reviewing court held that the complaint alleging the breach of the covenant not to compete and establishing a sum to be paid as liquidated damages was sufficient to form the basis of a suit.—*Oudenhoven v. Nishioka*, 190 N.W. 2d 920 (Wis. Sup. Ct., Nov. 2, 1971).

**Pathologist's Report May Be Admitted into Evidence**—A pathologist's report concerning a deceased patient should have been admitted into evidence during a malpractice trial, according to a Michigan appellate court.

A 26-year-old patient had a malignant lump on her breast. Her physician performed a radical mastectomy. The patient was then taken to an operative recovery room. Several

hours later, it became apparent that the patient's condition was rapidly deteriorating. Her physician was located and remained at her side until she died, shortly thereafter.

A postmortem examination was conducted by a pathologist, who wrote up a report which became a part of the hospital records. Suit was thereafter brought against the physician and the hospital, charging negligence in the death of the patient.

At the trial, the pathologist's report was offered as an exhibit. The trial judge refused to admit the report as an exhibit but did permit its author to be cross-examined concerning his report. Cross-examination indicated pathological findings of cerebral edema, hypoxia, hyperemia, and acute pulmonary edema. All of these conditions may be caused by a shortage of oxygen and they could all produce death. Since the furnishing of oxygen to the patient was the duty of the hospital, the pathologist's report was damaging to the hospital.

In affirming a jury verdict for the physician, the court stated that there was no medical testimony that the physician's handling of the case was not in accord with the standard practice of skilled physicians in the community. However, the court reversed the verdict for the hospital and ordered a new trial.

The court held that the pathologist's report should have been admitted into evidence. A state statute authorized the admission of such evidence. As an admitted exhibit, the report could have been available to the jury during its deliberations. The fact that the report was unavailable was prejudicial.—*Abbe v. Woman's Hospital Association*, 192 N.W. 2d 691 (Mich. Ct. of App., Aug. 23, 1971; rehearing denied, Oct. 8, 1971).

**Physicians not Compelled to Make Pretrial Admissions**—In a wrongful death action, physicians could not be compelled to furnish pretrial admissions of facts if they were willing to risk fines or perjury



prosecutions for denying requests for the admissions, a California appellate court ruled.

After the death of a woman and her unborn child at the time of delivery, her husband and children brought action against the attending physician, the anesthetist, the hospital, and a drug manufacturer. Two sets of interrogatories were filed and answered concerning the physicians' professional training and experience and the anesthetist's legal status in relation to the deceased woman.

The drug company filed requests for admission of genuineness of an autopsy report, a microscopic report, a neuropathology report and a chemical analysis, all by the coroner's office. There was also a request for admissions of genuineness of such facts as the site of an injection of an anesthetic, the deceased woman's height and weight and certain facts relating to the autopsy.

Counsel for the husband served identical requests on the two physi-

cians, who denied them. The husband filed a motion for an order to compel further answers to the requests or to deem them admitted and impose sanctions. The motion was denied.

The husband then commenced what was described by the court as an unprecedented flurry of activity. Lengthy second and third sets of requests for admissions, concerning facts surrounding the woman's death, were filed. The physicians denied almost all requests. Counsel for the husband then filed third, fourth, fifth, sixth and seventh sets of interrogatories, most of which were denied.

The husband filed responses to requests by the drug company. He admitted most requests but denied a request for admission that the woman had weighed 200 lb. at the time of her death and for facts relating to treatment and to the autopsy, the truth of which he was unable to determine.

When the matter came on for hearing, the court ordered further answers

to the fifth set of interrogatories, calling for factual bases for the physicians' denials of facts, and ordered the physicians to supply information as to the height of the woman at the time of death. The court denied all other relief.

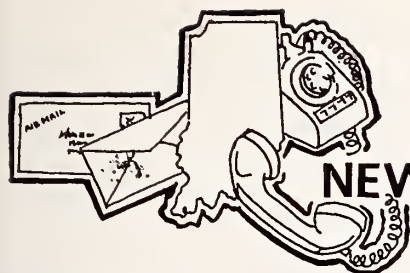
The husband sought reversal of the trial court's refusal to compel further discovery from the physicians. The appellate court said that the husband seemed to feel that the physicians had a duty to start an investigation with persons who participated in the autopsy and answer the interrogatories according to information they gathered, even if the facts they learned were antagonistic to their own case. The court denied the husband's request, holding that there was no principle of law compelling a party to both prepare his opponent's case and stipulate away his own.—*Holguin v. Superior Court of the State of California for the County of Los Angeles*, 99 Cal. Rptr. 653 (Cal. Ct. of App., Jan. 12, 1972).

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## Medicare Approval Granted Lab

Since publication in the June issue of the list of Medicare Approved Independent Clinical Laboratories in Indiana, one additional laboratory has been granted approval and should be added to the list on page 642 of the Yearbook. It is

Chem-Tech Laboratories, Inc.  
2907 Parnell Ave.  
Fort Wayne 46805.



## NEWS NOTES

### Texans Hear from Dr. Guy Owsley

Dr. Guy A. Owsley, Hartford City, was a featured speaker at the 105th annual session of the Texas Medical Association House of Delegates recently. He discussed the concepts of utilization review and peer review and their effects on physicians.

Dr. Owsley is chairman of the AMA Council on Medical Service.

### Dr. Stonehill Resigns As Indiana RMP Head

Dr. Steven C. Beering, Indianapolis, associate dean of Indiana University School of Medicine, is acting coordinator of the Indiana Regional Medical Program, pending the selection and appointment of a coordinator to replace **Dr. Robert B. Stonehill**, who has resigned as coordinator to devote full time to teaching and clinical work.

### Mortons Named Winners Of Little Red Door Award

**Dr. and Mrs. Joseph L. Morton**, Indianapolis, were recently honored by the presentation of the Little Red Door Recognition Award "for dedicated service in the fight against cancer." Dr. Morton is head of the radiology department at St. Vincent Hospital and chairman of its cancer committee. His wife, Mary Frances Morton, a registered nurse, has long been a volunteer with Little Red Door, serving as a home visitor.

The award was made at the 26th annual meeting and was only the fourth presentation of the award in the group's history.

Physicians newly elected to the board of the Marion County Cancer Society are **Drs. Virginia M. Wagner and Arvine G. Popplewell**, Indianapolis.

### New Booklet Offered

The Pharmaceutical Manufacturers Association has published a booklet "The Medications Physicians Prescribe: Who Shall Determine the Source?" to explain the background and purposes of antisubstitution laws and regulations, and to explain the reasons why such laws are desirable and necessary. Copies may be obtained by writing the Association at 1155 15th St., N.W., Washington, D.C. 20005.

### Dr. Fisch on Cardiology Congress Panel

**Dr. Charles Fisch**, Indianapolis, was one of the panelists who discussed "Effects of Acetylcholine on His-Purkinje Automaticity and Conduction" during the Scientific Session of the American College of Cardiology recently.

### Drs. Warren Share Fermi Award

Dr. Shields Warren of Boston and Dr. Stafford Warren of Los Angeles are the joint recipients of the Atomic Energy Commission's Enrico Fermi Award for 1971. The two Drs. Warren are not related. They are both leading medical experts on radiation. This is the first time in the history of the Award, which has been given 14 times previously, that it recognizes contributions to medicine and biology.

### Attains "Distinguished" Rank

**Dr. John I. Nurnberger**, chairman of psychiatry at Indiana University School of Medicine, has been honored by being named Distinguished Professor, the top honor and rank awarded by Indiana University. Dr. Nurnberger is also director of the Institute of Psychiatric Research, and is nationally known as an educator and researcher.

### Participates in Arthritis Forum

**Dr. R. E. Echeverria**, Elkhart orthopedic surgeon, was one member of a panel who discussed arthritis, its care and treatment and research being done in the field at a recent forum co-sponsored by the Elkhart County Arthritis Foundation and Alpha Omicron Pi alumnae of the area.

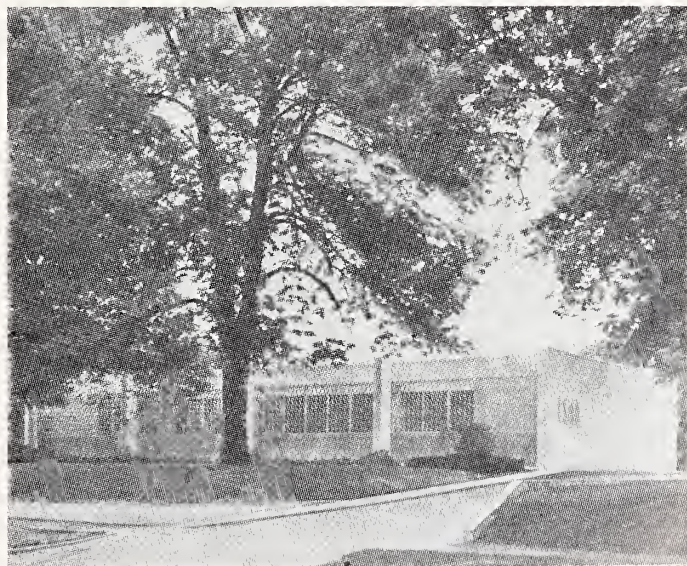
### Officers to Organize New Hospital Staff Chosen

The Medical Staff Formation Committee of the Munster Community Hospital elected interim officers at a recent meeting of more than 60 Lake County doctors.

Officers who will organize the hospital staff are Dr. David M. Harvey, president; Dr. C. D. Egnatz, vice president; Dr. James Maroc, secretary; and Dr. W. V. Hehemann, treasurer.

### "Women and Smoking" Subject of Booklet

Public Affairs Pamphlet "Women and Smoking" debunks the glamour of smoking and discusses the disadvantages. The authors are Jane Brody, a science writer for the *New York Times*, and her husband Richard Engquist, an editor. The pamphlet is especially recommended for reading by young girls, since the onset of smoking in women is occurring at younger and younger ages. Public Affairs Pamphlet #475 is available at 25 cents a copy from Public Affairs Committee, 381 Park Avenue South, New York City 10016.



TEN YEARS AFTER the Indiana State Medical Association moved into its new headquarters finds the building in frequent use for meetings. During the first five months of 1972, 51 meetings were held in the building, including 37 of ISMA Commissions and Committees and 14 of related medical groups and specialty societies and such groups as Directors of Medical Education and the Indiana Regional Medical Program Board. Some groups meet on Saturday and/or Sunday and frequently more than one meeting takes place in the building at the same time. The meeting schedule is on the increase with more and more medical and related groups taking advantage of the excellent meeting facility.



## Speaks at Med Ed Congress

**Dr. Richard W. Campbell, Indianapolis**, spoke on "Continuing Education for Prospective Medicine" during the AMA's Annual Congress on Medical Education recently, and **Dr. Jack H. Hall, Indianapolis**, spoke on "Planning for Future Change." Dr. Hall is president of the Association for Hospital Medical Education.

## Elected to Pediatric Academy

**Drs. Don R. DuBois, Greenwood, Philip Hedrick and Loraine Kelley, Indianapolis, and S. R. Sera, Bedford**, were elected to Fellowship in the American Academy of Pediatrics at its recent spring session in San Diego.

## Serves as Chairman

**Dr. B. L. Martz** served as chairman of the session on Cardiovascular Pharmacology during the annual Scientific Session of the American College of Cardiology.

## Sports Medicine Discussed

Approximately 60 high school coaches, athletic directors, trainers and team physicians discussed various aspects of sports medicine at a recent program held at the Purdue Memorial Union. Jointly sponsored by the Purdue Student Hospital, ISMA, the Tippecanoe County Medical Association and the Indiana Orthopaedic Society, the day-long program included presentations by both physicians and athletic trainers.

**Dr. John T. Burns, Lafayette**, president of the Tippecanoe County Medical Society, and **Dr. L. W. Combs, Purdue** team physician, served as moderators.

## Speaks at Cardiology Session

**Dr. Walter J. Daly, Indianapolis**, spoke on "Pulmonary Embolism and Cor Pulmonale" during the 21st annual Scientific Session of the American College of Cardiology.

## New Pediatric Surgery Director Named by IU

**Dr. Jay L. Grosfeld** has been appointed director of pediatric surgery for Indiana University School of Medicine. He is leaving New York University School of Medicine, where he was director of pediatric surgery, to direct education, patient care and research in the School of Medicine and in the Riley Hospital.

## New Pamphlet Tells How to Talk With Preenagers about Sex

Public Affairs Pamphlet No. 476 tells how to talk with pre-teenagers about sex. It is written by **Sadie Hofstein**, a consultant on child development and parent education. Copies are available at 25 cents per copy from the Public Affairs Committee, 381 Park Avenue South, New York City 10016.

## Dr. Jack Whitaker Speaks

**Dr. Jack Whitaker**, pathologist at Community Hospital, Anderson, was the featured speaker at the annual spring dinner of the Loan Cupboard for Cancer Patients in Madison County. He was introduced by **Dr. William Tierney**, Anderson surgeon.

## Notre Dame, IU Received Hartford Foundation Funds

The Hartford Foundation announces continued support during 1971 to Indiana University Foundation for two research projects, "A search for evidence of cytoplasmic inheritance in man" and "Investigations of axoplasmic flow: The transport of materials in nerve fibers."

Continued financial support is also announced for the University of Notre Dame for "Studies on resistance to carcinogenesis and tissue transplantation in germfree rodents." These are three of the 97 grants made in 1971 for biomedical research. The Foundation's net appropriations last year totaled \$13,475,225.

## Three Hoosier Students Win Nuclear-Related Exhibit Awards

The Atomic Energy Commission has announced the names of winners of AEC Special Awards for outstanding nuclear-related exhibits at the 23rd International Science and Engineering Fair at New Orleans.

Two of the 10 national award winners are Hoosiers. **Harold J. Loveridge, 17**, senior at Southwestern High School of Lafayette won on an exhibition on "Restoration of X-Irradiated Lymphoid Tissues in Mice Using DNA Injections." **William A. Fisher, 16**, junior, Marian High School, Mishawaka, won with an exhibit on "Focusing X-Rays."

There were also 10 Special Award alternates chosen nationally. Two of these students are from Indiana. **Mark J. Gladieux, 15**, sophomore, Bishop Dwenger High School, Fort Wayne, exhibited "The Development of a Radioisotope Calibration Technique." **Deborah Lynn Hanish, 16**, junior, Marquette High School, Michigan City, won on an exhibit "Applications of Nucleic Acid Analogue and Radioactive Metal Complexes on Agrobacterium."

The principal winners and their teachers will attend an expense-paid "Nuclear Research Orientation Week" in mid-August at the AEC's Argonne National Laboratory.

## NOW IN OUR 111th YEAR OF RESTORING CONFIDENCE TO THE DISABLED

The year 1972 marks one hundred and eleven years of service in the field of prosthetics for the Hanger Organization. Over the years the name Hanger has become synonymous with fine prosthetic appliances.

Today, there are over 50,000 persons who rely on Hanger Prostheses—more than any other make.

Hanger's complete line of arm and leg prostheses for all types of amputations are constantly being improved through research. Along with the most modern in Prosthetic equipment, Hanger offers the services of our highly qualified staff of Certified Prosthetists. Each Hanger Prosthetist is well versed in the latest developments through regular attendance of College Prosthetic Seminars.

There are over 40 Hanger Offices in principal cities throughout the United States and Canada.

**Hanger**  
PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202  
312 E. McMillan St., Cincinnati, Ohio 45219  
416 N. Main Street, Evansville, Indiana 47711  
3004 S. Wayne Ave., Fort Wayne, Ind. 46807



Riley Hospital's Decor A Winner

The Riley Hospital for Children is the recipient of one of the 1972 Burlington House Awards in the institutional category for creatively using the tools for interior design to make the work of the institution more effective. The Riley was one of seven institutions nationally to be so honored. Burlington House Awards have been issued for residential structures for the past four years. This is the second year for institutional recognition. Other facilities cited this year included general hospitals, a senior citizens' home, a child study center, a county jail annex and a child development and mental retardation center. Burlington House invites nominations for consideration for the 1973 Awards Program. Entries should be made prior to August 31. Address Letitia Baldrige, 1345 Avenue of the Americas, New York City 10019.

Appointed by PMA

Dr. Archibald M. Brunton, Indianapolis, has been appointed assistant vice president, Scientific and Professional Relations, and director, Office of Medical Affairs of the Pharmaceutical Manufacturers Association. Before joining PMA Dr. Brunton was medical director, Human Health Research and Development Laboratories, Dow Chemical Company.

Seven Named ACP Fellows

The American College of Physicians announces the induction into Fellowship of **Drs. Richard W. Campbell, Stanley M. Chernish, H. William Gillen, Jack H. Hall, Leroy H. King, Jr., Stuart A. Kleit** and David M. Smith, all of Indianapolis.

Childhood Drug Abuse Prevention Brochure Offered by NIH Division

"Tips on Drug Abuse Prevention for the Parents of a Young Child" is a brochure prepared by the Division of Narcotic Addiction and Drug Abuse of the National Institute of Mental Health. Copies of the brochure may be obtained by writing the National Clearinghouse for Drug Abuse Information, P.O. Box 1080, Washington, D.C. 20013.

Many View ISMA Exhibits at Convention/Exhibition Center

THE Indiana State Medical Association's exhibits at "Indiana on Review" drew as much, if not more, attention than any other exhibit. For the premiere show at the brand new \$26,000,000 Indiana Convention/Exposition Center in Indianapolis, ISMA brought in the



Thornhill Certified by AAMI

Kenneth J. Thornhill of the Methodist Hospital, Indianapolis, has been designated a Certified Biomedical Equipment Technician by the Association for the Advancement of Medical Instrumentation. Certification validates that the designee has met the education and experience requirements established by the Board of Examiners and has passed the Certification Examination.

VA Names Dr. Puestow 1972 Distinguished Physician

Dr. Charles B. Puestow, Professor Emeritus of Clinical Surgery at the University of Illinois College of Medicine and Graduate School, who has been Chief of the Surgical Service at the Hines, Illinois, VA Hospital for 26 years, has been appointed the Veterans Administration Distinguished Physician for 1972.

Dr. Currie Closes Office

**Dr. Robert W. Currie** has closed his north Indianapolis radiological office. Film records are available by calling his home (251-8517) until on or about August 1; after that time communications should be addressed to him at 624 Royal Lane, Celina, Ohio 45822.

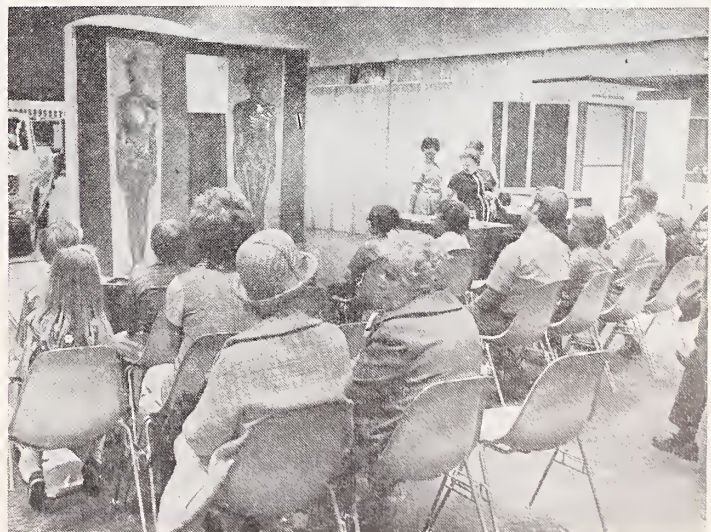
Attend ASIM Meeting

**Dr. John L. Ferry, Hammond, and Dr. D. Edmund Storey, Indianapolis,** attended the annual meeting of the American Society of Internal Medicine at Atlantic City April 14-16 as delegates from the Indiana Society of Internal Medicine.

Drug Price Booklet Offered

The Pharmaceutical Manufacturers Association has just published a booklet to show the decline in prices of prescription drugs. Total medical care costs have risen about 50% since 1960, a period in which prescription drug prices have decreased by 10%. Copies of the booklet are obtainable by writing the PMA, 1155 Fifteenth St., N.W., Washington, D.C. 20005.

AMA "Transparent Twins" and "Life Begins" exhibits. Literally thousands took time during the 10-day show to view the two exhibits. ISMA staffers said it was beautiful to watch the number of parents who took advantage of the exhibits to teach their children something about the development of life and the human body. The exhibits drew special attention from the press and radio.





## Named OB-GYN Fellows

Drs. David M. Dersch, Muncie; James L. Mount, Bedford; and Martin T. Feeney, Indianapolis, were recently installed as Fellows of the American College of Obstetricians and Gynecologists at the annual meeting of the college in Chicago.

## Reelected to Three-Year Term

Mr. Eugene N. Beesley, chairman, Eli Lilly and Company, has been reelected to a three-year term on the Board of Directors of the Pharmaceutical Manufacturers Association.

## Tells of Russian Medical Practices

**Dr. Edward P. Mininger, Elkhart**, described medical services in the USSR for members of the Elkhart Rotary Club recently.

## Dr. Will C. Moore Honored

**Dr. Will C. Moore, Muncie**, was honored recently at a luncheon meeting of the board of directors of the Delaware County Cancer Society. He was presented with a plaque in recognition of his many years of service to the Society.

## Pfizer Funds Symposium on Venereal Disease

Pfizer, Inc., one of America's oldest pharmaceutical firms, funded a recent state symposium on venereal disease held at Indiana State University. Local agencies cooperating in the symposium were the Vigo County Health Department and the Vigo County Medical Society.

The company annually sponsors a national symposium and several smaller ones throughout the country as part of its ongoing nationwide public health education efforts related particularly to venereal disease, mental health and diabetes.

## Merger Found not Feasible Now

The proposed amalgamation of the American College of Physicians and the American Society of Internal Medicine has been determined to be not feasible at the present time. The two organizations will continue a program of liaison and cooperation.

## New Pharmacy Director Appointed

Roland F. Harding has been named director of pharmacy service for the VA. He succeeds Donald E. Francke, who has been acting director and who will now head clinical pharmacy research for the VA.

## Dr. Max Norris Honored

The Society for the Advancement of Management's Indianapolis Chapter selected **Dr. Max S. Norris, Indianapolis**, as one of the recipients of the society's annual management awards. The citations are given in recognition of significant contributions in practicing and advancing the art and science of management.

## "Family Practice" Dr. Frank's Topic

Dr. L. Louis Frank, Jr., director of the family practice residency program at Memorial Hospital, South Bend, addressed a recent state meeting of Alpha Epsilon Delta, pre-medical honorary at Indianapolis. His topic was "Family Practice in the Future."

## Walkerton Physician Made Honorary Fireman

Dr. Bryce Rohrer, Walkerton, who volunteered to teach a training course last summer and then a refresher course this spring in

closed heart massage, control of excessive bleeding, emergency childbirth and applying oxygen to heart attack victims, was made an honorary member of the Koontz Lake-Oregon Township Volunteer Fire Department recently. Dr. Rohrer was also presented with an engraved plaque in appreciation of his services.

## Elected Director of Royal Society

Bryce Douglas, Ph.D., Vice President, Pharmaceutical Research and Development, Smith Kline & French Laboratories, has been elected a member of the board of directors of The Royal Society of Medicine Foundation. Dr. Douglas received degrees from Glasgow University and Edinburgh University and did research work at Harvard University, Aberdeen University, Indiana University and the National Research Council of Canada before joining Smith Kline & French in 1956. The Royal Society of Medicine Foundation was formed in 1967 to encourage individuals and institutions in the United States to support medical research in Great Britain and to foster closer relations between members of the medical professions of both countries.

## Purdue Pharmacy Graduate Wins 1972 Kilmer Prize

A member of the graduating class of the Purdue School of Pharmacy has won the Kilmer Prize for the fourth consecutive time. The award is made nationally for the best paper based upon research in pharmacognosy by a graduating student of any accredited college of pharmacy. The winner for 1972 is Steven R. Adams, Fort Wayne. Mr. Adams extracted and purified an enzyme from cottonseed root which may lead to new knowledge concerning the utilization of cholesterol by the human body.

## Aetna Offers Increased Catastrophic Coverage

Aetna plans to offer the holders of its policies for medical expenses under group insurance plans the option of increasing coverage for catastrophic expenses up to a limit of one-quarter of a million dollars—five times the present limit of \$50,000. The cost will vary with the type of plan already carried, but will involve an increase of less than one percent in the cost of the present plan. The new plan also includes a limitation of \$1000 on the amount that any individual will be required to pay out of his own pocket to meet the normal cost control requirement.

## Wins First Place in Art Contest

**Dr. Joseph Begley, Evansville**, won first place in the art category with an oil painting he entered in the St. Mary's Hospital Centennial Art Exhibit. More than 200 exhibits created by employees, volunteers and medical staff members were entered.

## On Panel at Bridal Fair

**Dr. John K. MacLeod, South Bend** obstetrician and gynecologist, represented the medical profession on a panel of experts who fielded questions from brides-to-be at a recent Bridal Fair held in the Athletic and Convocation Center at the University of Notre Dame. In addition, a banker gave financial advice and a minister offered marriage counseling.

## Paregoric Sales Restricted

Effective June 3, paregoric and other products containing more than 100 milligrams of opium per 100 milliliters or per 100 grams are restricted to prescription sale. The FDA found the change was necessary because of the abuse potential of such products. ◀

*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

— George Sarton, from *"The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

**No, it would not be useful.**

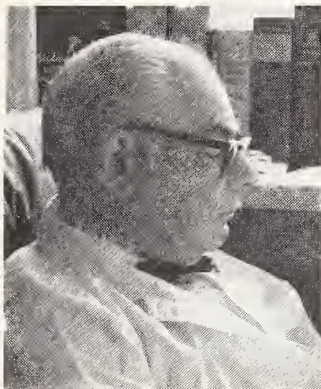


# Opinion & Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

in practice can really be determined.

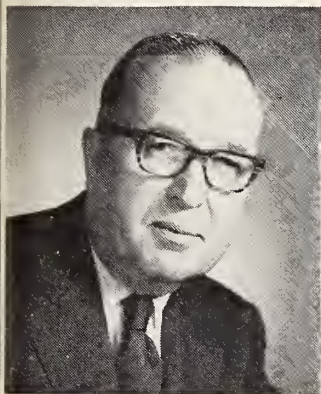
The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. And I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the one "drug of choice" in all areas of medical practice.



## Maker of Medicine

Kenneth G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Eli Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, and then it will be based on his experience with this drug and his knowledge of the individual patient who is seeking treatment.

If an evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a great disservice to medicine and thus to the patient—the consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at this time the new drug could be labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. Later, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use—information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

What is your opinion, doctor?

Send us your comments on the above issue.



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# *The Woman's Auxiliary* REPORTS TO ISMA

Summertime is well upon us now—after a spring that was slow getting started. It's a more relaxed time for many of us—school is out, the children are home—except for those who are industriously attending summer sessions. We have the opportunity to enjoy summer activities such as vacation travel, golf, boating, and lake-living. We in Indiana are fortunate to be able to observe four definite seasons—and each period has its own charm.



Summer is a time for catching up on auxiliary activities, also. We have completed most of the business of the year just past, and are well underway on our activities and projects for the current year. The AMA convention has just concluded in San Francisco, which brings to mind some thoughts about conventions.

Conventions, conferences and clinical sessions have become also a year-round occurrence. This gives us an opportunity to choose the time of year and location that best suits our schedule as well as our area of interest.

To be able to combine business with pleasure is an added bonus and can also save us money. With careful planning it is often possible to combine clinical work and travel. Adding a few days for fun and sightseeing onto the time required for meetings can often pay big dividends. A chance to really relax, with no tight schedules to meet—no pressures from the phone and patients, can well perk up your health and give you renewed vigor to again attack the workaday world.

The wives often have activities planned for them while you are attending meetings, but do let them check your schedule. Perhaps there will be some sessions they would find of interest and would like to attend with you. If you share your daily activities with your wife and she listens to your table-talk, new developments and techniques in your field should be of interest to her.

Conventions offer a great opportunity for sight-seeing—but do plan ahead! Read all you can about the area you plan to visit—know what you want to see and reject that which you might not appreciate as a waste of valuable time. Make every moment count. If you have a special avocation, look for any activities along this line. If you enjoy fishing—perhaps you will have an opportunity for deep sea fishing or attacking a clear mountain stream. Most large cities have wonderful art galleries for those more esthetically inclined. And unusual eating places will intrigue the gourmet in all of us. Of course, the number one pastime of all women is shopping—and everywhere you go will have its unique shopping areas—many of them peculiar to its own geographic location.

Above all, plan ahead, so that you can return home with a great feeling of exhilaration and satisfaction with time pleasantly spent.

A wise person once said "Take half as many clothes and twice as much money as you think you need when traveling." Enough said!

Next month I'll report to you on the Woman's Auxiliary to the AMA's 50th anniversary, which was celebrated at the meetings in San Francisco. May the next 50 be as exciting and rewarding as the first half century.

Have a happy, safe July.

*Marjorie Smith*



# Deaths

## Frank W. Bussard, M.D.

Dr. Frank Wakefield Bussard, South Bend, died of a massive cerebral hemorrhage while swimming in the YMCA pool May 30. He was 54.

An avid scuba diver, Dr. Bussard specialized in aquatic medicine. He was an active member of underwater demolition teams and seal teams on the Atlantic and Pacific Coasts and at St. Thomas, Virgin Islands. He assisted in the scuba training of astronauts in the early stages of the U.S. space program.

A graduate of the Indiana University School of Medicine in 1944, he had been a general practitioner in South Bend 25 years. During the Korean War he was recalled to active duty in the Navy.

In 1970, after 28 years of service, he retired from the Navy Reserve Medical Corps with the rank of commander.

He was a member of the St. Joseph County Medical Society and the Indiana Academy of General Practice.

## David R. Johns, M.D.

Dr. David R. Johns, 85, who practiced in East Chicago from 1912 to 1956, died at Beloit, Wis., where he had made his home for eight years.

Dr. Johns served as chairman of the Indiana State Board of Health from 1945 to 1949 and as health commissioner of East Chicago from 1942 to 1945.

Active in the Industrial Medical Association, Dr. Johns was nationally known for his work with lead poisoning and silicosis treatment.

He was a graduate of Loyola University Medical School and served as a first lieutenant in the Army Medical Corps during World War I.

Dr. Johns served as president of the Lake County Medical Society in 1947.

## John K. Kingsbury, M.D.

Dr. John K. Kingsbury, Indianapolis, named "Doctor of the Year" by the Indiana State Medical Association in 1959, died January 17, 1972. He was 86 and had been a member of the Marion County Medical Society since 1910.

He was a graduate of the Indiana Medical College, where he helped in the study of pernicious anemia and Hodgkin's disease, in 1909. During his internship at St. Vincent Hospital he made and used autogenous vaccines. Dr. Kingsbury served as team physician for Butler University for many years. He was a 50-year member of the American Medical and the Indiana State Medical associations.

## Harry E. Kitterman, M.D.

Dr. Harry E. Kitterman, 71, a medical director of the Indiana State Welfare Department since his retirement from active practice in 1967, died June 2 in Community Hospital, Indianapolis.

A Navy veteran of both world wars, Dr. Kitterman was a 1928 graduate of the Indiana University School of Medicine and was a member of the American College of Surgeons, the International College of Surgeons, the AMA, ISMA and Marion County Medical Society. In 1971 he became a Senior Member of the latter organizations.

## William M. Loehr, M.D.

Dr. William M. Loehr, 62, Indianapolis, associate professor of radiology at the Indiana University School of Medicine, with which he had been associated since 1940, died May 1 at his home.

A graduate of the University of Louisville School of Medicine, Dr. Loehr served as a lieutenant colonel in the Army during World War II and was recalled to duty during the Korean War. From 1936 to 1939 he had been in general practice at Versailles.

A past president of the Indiana Roentgen Ray Society, he was also a member of the American Roentgen Ray Society, Radiological Society of North America, Marion County Medical Society, AMA and ISMA.

## Mavor J. Moss, M.D.

Dr. M. J. Moss, 62, died March 29 in Ball Memorial Hospital, Muncie, after a two-month illness.

Dr. Moss retired May 1, 1969, after practicing at Yorktown following graduation from the Indiana University School of Medicine and internship at Indianapolis General Hospital.

In 1961 he was appointed to the State Board of Health and served as chairman of the board in 1969 and 1970.

He served as a captain in the United States Army during World War II and was a member of the Delaware-Blackford County Medical Society.

## Ralph Ploughe, M.D.

Dr. Ralph Ploughe, Elwood, 74, died March 25 in his home following an extended illness. He had practiced medicine in Elwood until January of this year.

He was graduated from the Indiana University School of Medicine in 1925 and served an internship at the League Island Navy Hospital, Philadelphia. During World War II he served with the U. S. Navy.

From 1964 to 1967 Dr. Ploughe served on the ISMA Commission on Aging. He was a Senior Member of the Madison

County Medical Society, the ISMA and the American Medical Association.

## Russell A. Sage, M.D.

Dr. Russell A. Sage, 75, who had practiced medicine at Indianapolis since 1932, died April 11 at his home.

He served on the staffs of St. Vincent and Methodist Hospitals and was an associate professor at Indiana University Medical Center. He was graduated from the Indiana University School of Medicine in 1928 and was a member of the American Academy of Ophthalmology and Otolaryngology and the Marion County Medical Society.

He saw service in World War II with the U. S. Army.

Memorial contributions were made to the Russell A. Sage Fund for Medical Education in care of the Marion County Medical Society.

## Max C. Salb, M.D.

Dr. Max C. Salb, 67, who retired from practice in Indianapolis in 1964, and resided at Kuttawa, Ky., died April 19 while horseback riding with his wife near their home.

A former member of the Marion County Medical Society, Dr. Salb had served as medical director of the Eddyville, Ky., State Prison for four years and held that position at the time of death.

## Frank E. Sayers, M.D.

Dr. Frank E. Sayers, a practicing Terre Haute physician for 27 years, died May 4 at a Terre Haute nursing home. He was 83 and retired because of ill health in 1949.

A graduate of the University of Michigan Medical School, he interned at Youngstown Hospital, Youngstown, Ohio, and studied at the Mayo Clinic after World War I. He served as a medical officer in the Navy and Marine Corps for 27 months.

He was a member of the Vigo County Medical Society.

## Frank M. Thompson, M.D.

Dr. Frank Magill Thompson, 59, Columbia City, died April 28 in St. John's Hospital, Springfield, Ill.

In 1937 he received his M.D. degree from Western Reserve University's School of Medicine and had practiced at Huntington and Columbia City. He was a medical officer in the U. S. Navy in World War II.

A Fellow of the American College of Physicians, he was a member of the Whitley County Medical Society and was president of the medical staff of Whitley County Memorial Hospital. He was a coordinator and organizer of the Whitley County Drug Education Advisory Council.

# County, District News

## First District

Election of officers took place at the April 13 meeting of the First District Medical Society with the following result: President, Dr. Bernard B. Rosenblatt; vice president, Dr. William Dye; and secretary-treasurer, Dr. John Winebrenner. All are of Evansville.

ISMA President Dr. Peter Petrich gave a comprehensive report on medical events at the state level and Dr. James Gosman, president-elect, also spoke.

## Second District

The Second District Medical Society met at Linton on May 18 and re-elected Dr. J. S. Brown, Carlisle, secretary. The Owen-Monroe group will select the District president and the 1973 meeting will be held at Bloomington.

Dr. Paul W. Holtzman, Bloomington, was elected trustee, his term to run from October 1972 to October 1975.

## Fourth District

More than 60 physicians and their wives attended the May 17 meeting of the Fourth District Medical Society at Madison.

Dr. Kenneth Schneider, Columbus, was elected president; Dr. Jack Shields, Brownstown, president-elect; and Dr. C. David Ryan, Columbus, secretary. The 1973 meeting will be held in Columbus.

Dr. Jack Shields resigned as trustee, effective October 1972, and Dr. Howard C. Jackson, Madison, will serve the unexpired term of Doctor Shields which ends in October 1974. Dr. William F. Blaisdell, Seymour, was elected alternate trustee to serve the unexpired term of Doctor Jackson which expires in October 1973.

Dr. Alvin Henry, Columbus, was elected Blue Shield director.

## Fifth District

Dr. James C. Lett, Greencastle, was elected president of the Fifth District Medical Society in a meeting at the Terre Haute Country Club on May 24. Dr. J. Franklin Swaim, Rockville, was elected secretary-treasurer. More than 75 persons were on hand for the dinner.

The 1973 meeting will be held at Greencastle.

Dr. Cleon M. Schauwecker, Greencastle, was elected trustee, and Dr. William G. Bannon, Terre Haute, was elected alternate trustee to fill the unexpired term of

Doctor Schauwecker which expires in October 1973.

## Sixth District

The Sixth District Medical Society convened at 3:00 on May 3 with 45 members present to hear a discussion of current socio-economic matters. Dr. Guy Owsley, Hartford City, discussed peer review; Dr. D. Edmund Storey, Indianapolis, presented a discussion of medical foundations; and Dr. Raymond H. Murray, Indianapolis, explained health maintenance organizations.

Election results were as follows: President, Dr. John Moenning, Greenfield; vice president, Dr. James H. Tower, Jr., Shelbyville; secretary-treasurer, Dr. Davis Ellis, Rushville; and alternate trustee, Dr. Glen Ward Lee, Richmond.

The 1973 meeting will be in Rushville.

Dr. Walter Judd, Minnesota's long-time Congressman and former medical missionary to China, was the after-dinner speaker.

## Eighth District

The Anderson Country Club was the site of the Eighth District Medical Society meeting on June 7 which was highlighted by a talk to some 72 physicians and wives after dinner by Dr. Otis R. Bowen, Bremen.

Drs. Peter Petrich and James Gosman spoke at the business meeting in the afternoon.

During the business meeting Dr. Richard Ingram, Montpelier, was re-elected trustee, and Dr. Jack Alexander, Muncie, was elected to serve the unexpired term of Dr. R. D. Williams as alternate trustee. Dr. David Dietz, Muncie, was named president; Dr. Arthur Jay, Muncie, secretary-treasurer. The 1973 meeting will be held at Muncie on June 7.

## Tenth District

One hundred twenty-five physicians, 90 wives and 20 teenagers attended the Tenth District meeting at the Lake of the Four Seasons Country Club on May 31.

Dr. Lambro Dimitroff, Calumet City, was re-elected president, and the new secretary elected was Dr. Mario Mansueto, Munster. Dr. Martin O'Neill, Valparaiso, was chosen alternate trustee; and Dr. William Fitzpatrick, Munster, Blue Shield board representative.

Dr. Edward R. Annis, past president of the American Medical Association, was the featured speaker after dinner.

## Allen

Dr. Donald E. Wood, Indianapolis, a member of the AMA board of trustees, addressed the 133rd annual meeting of the Fort Wayne-Allen County Medical Society on May 16.

## Bartholomew-Brown

Dr. Charles A. Rau, is the new president of the Bartholomew-Brown County Medical Society, and Dr. Edward L. Probst is the secretary. Both are of Columbus.

## Clark

Dr. Otis Bowen, Bremen, gave a brief talk at the April meeting of the Clark County Medical Society.

At the May meeting, which was held at the Red Cross Building in Louisville, members were briefed on the blood program.

Dr. George H. Rudwell, Jeffersonville, was elected secretary, and Dr. Claude J. Meyer, Sellersburg, will continue as president.

## Dearborn-Ohio

Dr. Ted Hornback, radiologist at the Indiana University Medical Center, spoke on radiation therapy to members of the Dearborn-Ohio County Medical Society on June 1.

Election was held, with the following to serve for the coming year: Dr. Gordon Fessler, Rising Sun, president; Dr. Delfin David, Rising Sun, vice president; Dr. Leslie M. Baker, Aurora, secretary-treasurer.

## Fountain-Warren

The Pfizer Company movie titled "Implications of Diabetes" was shown at the May meeting of the Fountain-Warren Medical Society.

In the election which took place Dr. Lowell Stephens, Covington, was chosen as president with Dr. T. C. Person, Veedersburg, named secretary-treasurer.

## Hancock

"Cardiac Arrhythmia" was the subject of the presentation made by Dr. Richard Lineback at the April meeting of the Hancock County Medical Society.



### Johnson

New officers for the Johnson County Medical Society are: Dr. Robert W. Ogle, Greenwood, president, and Dr. Paul Reynolds, Franklin, secretary.

### Kosciusko

On May 16 the regular meeting of the Kosciusko County Medical Society was held jointly with the medical staff of the Murphy Medical Center.

The following were chosen to serve as officers for the coming year: President, Dr. Harold Mason; vice president, Dr. Thomas Keough; secretary, Dr. Roland Snider. All are of Warsaw.

### LaPorte

Two new members were welcomed into membership of the LaPorte County Medical Society at the March meeting. They are Drs. Robert E. McBride and George Batacan.

Drs. Lawrence and Patricia Hartlage, of the Indiana University Medical Center, presented a program on Learning Disabilities at the April meeting.

Appreciation of the entire society to Drs. Barbara Backer and Peter J. Pilecki for the highly successful 1972 Health Careers Fair was expressed.

### Lawrence

Dr. Florian S. Dino moved into the presidency of the Lawrence County Medical Society at its May meeting. Dr. Lawrence E. Benham was re-elected secretary-

treasurer, Dr. Dino was renamed ISMA delegate, with Dr. James L. Mount the alternate delegate. All are of Bedford.

### Marshall

Dr. Richard Powell, Indiana University Medical Center, spoke on the subject of diabetes at the April meeting of the Marshall County Medical Society. His talk was followed by a question-and-answer period that lasted an hour.

At the May meeting Dr. Jose R. DeJesus, Jr., Plymouth, was elected president; Dr. James O. Coursey, Jr., Argos, vice president; and Dr. Lloyd C. France, Plymouth, secretary-treasurer.

### Porter

Dr. Robert Stepto, professor and chairman of the department of obstetrics and gynecology, Chicago Medical School, spoke on "What's New in Obstetrical Care" at the April meeting of the Porter County Medical Society.

The Society approved the formation of a trust fund with the following members as trustees: Drs. William McBride, John R. Crist, Zanita S. Pangan, Stewart Wu, Alfred J. Kobak, Jr., and Joel I. Hull.

### St. Joseph

At the May meeting the following officers were elected for the coming year: President, Dr. Stephen R. Phelps; president-elect, Dr. Robert D. Dodd; secretary-treasurer, Dr. Robert Nelson; assistant secretary-treasurer, Dr. David Spalding. Dr. J. O. Hildebrand was named

to a three-year term on the Board of Trustees and Dr. Bernard Vagner was named to a three-year term on the Board of Censors. All are of South Bend, except Dr. Spalding, who is of Mishawaka.

### Vanderburgh

Dr. William H. Getty is the new president of the Vanderburgh County Medical Society. Others to serve for the coming year are Dr. L. Ray Stewart, president-elect; Dr. C. Curtis Young, vice president; and Dr. Jerry D. Becker, treasurer.

Drs. George W. Willison, John D. Wilson, Ray H. Burnikel, Bernard B. Rosenblatt and Albert S. Ritz will serve as delegates to the state convention, with Drs. Weston A. Heinrich, Larry W. Sims, William D. Ritchie, Forest F. Radcliff, Jr., and John E. Heumann serving as alternates.

Drs. I. L. Heimburger and Ray W. Nicholson were named to the Board of Directors, and Dr. Paul Strueh will serve on the Board of Censors.

### Wayne-Union

Dr. Leon Goldman, chairman of the department of dermatology at the University of Cincinnati, presented a program of the use of lasers in medicine, industry and national defense at the April meeting of the Wayne-Union County Medical Society.

At the May meeting members heard a talk on peer review by Dr. Guy Owsley, Hartford City, chairman of the AMA Commission on Medical Services. ◀

A limited quantity of June Yearbooks and 1972 Rosters are available at the JOURNAL OFFICE, 3935 N. Meridian, Indianapolis 46208. Place your order now.

Yearbook: \$5.00 each.

Roster: \$3.00 each.

# Association News

## BOARD OF TRUSTEES

March 5, 1972

The Board of Trustees of Indiana State Medical Association met in regular session in the Headquarters building on Sunday, March 5, 1972. The meeting was called to order promptly at 8:30 a.m. EST by Dr. Joe Dukes, chairman, presiding.

Roll call showed the following:

District	Trustee	
1	Gilbert Wilhelmus	Absent
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Jack E. Shields	Present
5	Wilbert McIntosh	Present
6	Paul M. Inlow	Present
7	John O. Butler	Absent
7	Dwight Schuster	Present
8	Richard Ingram	Present
8	Wm. M. Sholty	Present
10	Vincent Santare	Present
11	Lowell Hillis	Present
12	Wm. R. Clark	Present
13	G. Beach Gattman	Present

District	Alternate	
1	Raymond Newnum	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Present
4	Howard C. Jackson	Present
5	C. M. Schauwecker	Present
6		
7	Joseph F. Ferrara	Present
7	Joseph C. Kerlin	Absent
8	Robert D. Williams	Absent
9	Max N. Hoffman	Present
10	Thomas C. Tyrrell	Present
11	James A. Harshman	Present
12	Walter D. Griest	Absent
13	Donald Chamberlain	Present

### Officers:

Peter R. Petrich	Present
James H. Gosman	Present
Lester H. Hoyt	Present
Hugh K. Thatcher, Jr.	Present
Frank B. Ramsey	Present

### Executive Committee:

Donald M. Kerr	Present
Wilbert McIntosh	Present

### Guests:

Don E. Wood	Present
Glenn W. Irwin, Jr.	Present
Andrew C. Offutt	Present
Richard Kilborn	Present
Kenneth Isenogle	Present

### Staff:

Robert J. Amick	Present
Howard Grindstaff	Present
John L. Walters	Present
Kenneth W. Bush	Present
James A. Waggener	Present

MINUTES OF MEETING HELD JANUARY 9, 1972, were approved as corrected on motion of Drs. Clark and Gattman.

### Reports of Guests

DR. GLENN W. IRWIN, DEAN, Indiana University School of Medicine.

DR. IRWIN: I thought you might be interested in our progress report concerning admissions for the Class of 1972. This year, as has been true the last two or three years, there have been about 1700 applicants; but the important thing is that the number of Indiana students or residents has jumped very substantially this year. For example, last year we had 672 Indiana residents apply but this year we have 112 more or 784 Indiana residents. In addition to that, about 1,000 out-of-state residents applied. The present freshman class of 275 students has an academic performance of 3.33 on a 4. scale. This is the average for the entire 275. Only eight students are from out of state. To give you some idea of the magnitude of the problem this year, of the 784 Indiana residents, 286 have a 3.3 to a 4. academic record at this point. Keep this in mind, 202 of these Indiana residents have an academic rank of 3.0 through 3.2 and only 288 are below the 3.0 average. We anticipate this trend continuing through the '70s and will probably level off around 1980, as most college enrollment will probably decline during that period.

While we have increased the entering class by almost 75 students during the last three years, we will have increased it by 100 additional entering students by 1973.

In spite of this massive increase in enrollment, you can see that we are obviously not able to take numerous students who are qualified, and this is true of the nation's medical schools right now.

A few words about the Family Practice Program. We have ordered what I consider a nice trailer at the wish of Dr. Alan Fischer. It is an office trailer for the corps of officers for the Department of Family Practice and it will be located near the Medical Science Building facing north and facing the General Hospital and it should be delivered in less than 30 days.

I would like to announce that after the Executive Committee meeting of the

RMP last week, Dr. Robert Stonehill will be resigning before March 15th, and I would like for this Association to participate in the selection of his successor. I will be glad to answer any questions.

DR. DUKES: How about the number of physicians graduating now compared to five years ago and do you think or when do you think we are going to catch up with this shortage?

DR. IRWIN: There are 214 in the 1972 graduating class and I might point out that about 65 to 70 of those graduated really last December. Our curriculum is flexible enough now that many students prefer to go straight through and not take a free quarter, but there are 214 in this class. This is the last of the small classes. There will probably be around 225 next year and then it goes on up. You see we entered 250 two years ago and that class will be out in about a year and a half, so it will soon go up. Next year will be 225; the following year will be about 250, the following year about 275; and then up to 320; and then we, of course, have a goal of 320 entering students next year but might have to go higher as things go.

DR. DUKES: What I meant was on the national level.

DR. IRWIN: Otis Bowen asked me that question and I had to answer it in this way and I don't have the data with me, but in the State of Indiana from 1958 through 1973, the increase was as I remember about 320. I know the percentage of increase was 6.9% in physicians where the state population increase was 2.9%. The national picture is that this year a little over 12,000 were admitted to the nation's medical schools and the applicant pool was 25,000 students; a little less than half of them found a place in an American medical school. The goal nationally is 15,000 graduates within or by 1976. There is a big move now on the part of 26 medical schools to go to a three-year curriculum, the kind that some of us went through during World War II. I would predict that perhaps half the nation's medical schools will have a three-year curriculum within a very few years. I really can't give you when we will reach the ratio of 200 physicians for 100,000 population in this country but, considering the new schools and the expansion of the existing schools, people are beginning to talk that in perhaps the 1980s we may or will be likely to catch up. We might even over-produce. It will seem strange in view of the problems that we have had, but that happened in about a decade in the case of engineers and physicists or biochemists and it could happen in medicine in the late 1980s.

Dr. Irwin went ahead to discuss the



membership of faculty members of the university with the county and state and AMA medical associations and discussed the work of the Admissions Committee in trying to screen out psychiatric individuals or those with emotional problems among the applicants for admission to the school.

DR. DUKES: Thank you, Dr. Irwin. Dr. Gosman, I would like for you to follow through with some of those faculty members and maybe we can work around so we can obtain more of them as members of this organization. And, Dr. Hillis, I would like for you to work with Dr. Gosman on this.

DR. DUKES: We will now hear from Dr. Offutt, State Health Commissioner.

DR. OFFUTT: Mr. Chairman and members of the Board, the major report which I would like to make to you is of course concerning the legislature and statutory problems that face the State Board of Health. The major difficulty at this time is money to match funds for Federal programs and, as of today, I don't know how the Budget Committee is going to rake up the money—like \$15 million for water pollution and some of these things that the Federal government is asking us to do.

There is every likelihood that we will close Silvercrest Hospital in New Albany, putting it on a standby basis, and try to sell it. There will also be a change coming out within the week, I suspect, on nursing services which will be rendered in nursing homes under the Medicaid program. There will be a reduction in the amount of service which will be paid for by welfare. I would like to express my appreciation for the support of the Indiana State Medical Association on the bills the Board of Health was concerned with. I have a hunch that a couple of them would not have gotten by had it not been for the State Medical Association's support of them. One of the things I thought we had pretty well ironed out was the problems in the Emergency Medical Care System. This was the one on the training of ambulance drivers. We thought it had an excellent chance of passage but it went down in defeat. I must tell you that I have been going to the legislature for 17 years and I have heard a lot of people talk about a lot of bills, but I never have heard anything that could compare with the presentation which was made by Dr. Joe McPike and Dr. John Farquhar about the Emergency Bill. Their testimony was excellent.

Unfortunately, the Legislature seemed to be more concerned about the quality of people who empty septic tanks than they were about the people who pick them up along the highway when they have had an accident. If you have any doubt about this,

we didn't have a bit of trouble in licensing the septic tank cleaners, but the Legislature is not about to let us license any ambulance driver or stewards and the reason we are not is because the funeral directors in the State of Indiana are telling us that we are not going to. Two other matters I would like to clear up while here are—the pre-marital sickle cell anemia bill, which creates a couple of problems with the Board of Health and a lot of problems from some other people. Basically, we will have to have some form to fill out saying that the individual has or has not had a test for sickle cell anemia. I have on my desk a draft of a proposal and the problem involves the cost which runs from \$3 to \$60. According to the best legal advice I have, the State Board of Health will not have to do these tests. We are hopeful, therefore, that the labs throughout the state will do those. There is also the bill on testing children who enter school for sickle cell anemia and this is the one, I recall, that you have to make the decision on. It was originally to the Board of Health and we managed to squirm out from under that one and now the doctor has to decide who shall have it or whether it is needed.

You all know that right now there are two premarital laws. One didn't make it and the other did. The premarital sickle cell anemia is a blood test like you do already for syphilis. Added to that is the one on sickle-cell anemia on those people who might have the disease, and the other sickle cell anemia test is one for school enterers.

QUESTION: Does the law say that the doctor simply says yes or no that they have had a test?

DR. OFFUTT: That is right. It is just like the other one which simply says whether or not you have been immunized for certain diseases. You don't have to be immunized. You just have to say whether you have been or not. The premarital blood test for immunity to rubella of course did not pass.

Dr. Offutt continued by discussing the Environmental Protection Act which was adopted by the legislature and stated he would like to clarify a misunderstanding which apparently got widespread about the bill that was introduced to transfer all professional health boards to the State Board of Health. This is a mistake. There was no effort on my part or the Board of Health's part to transfer any of those boards to the Board of Health. In attending several of these board meetings, of which I am a member, I have constantly heard about the difficulty they have had in getting the money they receive for licensure fees to spend in the operation

of their board. My only proposal was that we hire the staff under a merit system and that we establish a dedicated fund which after it receives or reaches \$500,000; any part above that should go to the general fund. We picked this figure because we went around to the boards and asked what they wanted for an operational figure. It also provided for the hiring of an attorney for the boards.

Questions were raised about the closing of Silver Crest and the reduction in nursing care for Medicaid patients, to which Dr. Offutt pointed out that by April 1st the Department of Public Welfare will not pay for more than 1.5 hours of nursing care for a 24-hour period in an intermediate care facility. However, this does not affect those patients they are paying for that require comprehensive care.

Dr. Offutt explained Silver Crest, pointing out that the legislature had given him only a dollar budget for Silver Crest when he has 30 some patients whom he will attempt to transfer somewhere. He said they would try to send as many as they could to the counties and/or some that have been court committed will probably come to Indianapolis where there are detention facilities, but the minute we can't support them any more what happens to them is the problem of the respective counties.

DR. DUKES: We will now move onto the President, inasmuch as Dr. Wood and Dr. Black are not present at this time.

DR. PETRICH: We have a bit of business that we have to take care of because we have researched it and I brought it up originally. It has to do with the convention sites as proposed to this organization by this body. As you know, we did officially change the convention site for this year, 1972, from French Lick to Indianapolis. We have outstanding, however, a commitment through the House of Delegates to have a convention in 1974 in Evansville. The consensus was that all conventions should be held in Indianapolis. At least that was the impression I had, and I think that most of you will agree. Therefore, Mr. Chairman, with your permission I would like to move that in the future all conventions be held in Indianapolis.

The matter was discussed by several and it was recommended by the chairman that, in the absence of Dr. Wilhelmus, action be postponed on this item.

DR. PETRICH: Now to get into the reports from the Commissions which I promised I would continue to do. I think probably the most far-reaching one is the Future Planning Committee which did, in fact, meet on January 16th and there



was a lot of discussion. The first thing that was brought up in the way of action was dealing with the Foundation concept again. It was the unanimous consent that the Future Planning Committee be an umbrella foundationist and that a state-wide Foundation on paper should be established in the not too distant future. Subsequent to this the Commission on Economics and Insurance met and discussed this same issue. There was a very good turnout at that meeting also and they intend to consider also the Foundations. They have requested a ream of information which Jim is undertaking to get for them in order that they might all study the background and information on the Foundation and to become knowledgeable, and they, in turn, will also make a report and/or recommendation. So just to keep them informed, I will report to them and we will keep you up to date on that commission. The Future Planning Committee also recommends that this Board give the Executive Secretary permission to employ one additional person for the purpose of handling legislation and government public affairs and further recommends that the committee feels that even additional personnel will be needed in the near future to fulfill the obligations of the association to the membership. They recommend that the Board consider employment in the future of additional personnel as needed and as appropriate budgeting and financial arrangements may be made.

DR. DUKES: Shall we take some action on this? Any discussion?

DR. CLARK: I think this is one of the finest reports I have read and I commend Jim on it. I think that the Headquarters office deserves and needs more help, and I move that the Board accept the things that he recommends.

A discussion was then held between the chairman of the Board and Mr. Waggener concerning the budgetary problems of employing another individual.

DR. DUKES: Well, why don't we get some more definite figures on this and you have to pick the man you want anyway and so find out how much he is going to cost and I think we had better study our lesson just a little bit. O.K., all in favor of the motion that further investigation be made say aye and those opposed same sign. The motion was carried that Jim will proceed with some more information and then come back to the Board.

DR. PETRICH: There was considerable discussion toward the end of this meeting about the Medical Disciplinary Act and the question was raised how does or could it have been mandated by the House of Delegates and not, in fact, in-

troduced in the Legislature.

It was explained that the Commission on Legislation did some detailed study and that they really did not have a consensus on what should be or not be in the Act and, in view of the fact that the Board of Trustees had taken the action that they have been holding area-wide meetings to deal with the model Medical Practice Act, which would include this particular kind of thing, it was moved and voted to delay action on the Medical Disciplinary Act in the 1972 legislature. You have all received information concerning the Commission on Legislation activities; therefore, I will pass it up.

The Commission on Special Activities—Dr. Hanus Grosz and his Commission dealt primarily with the methadone clinics and drug abuse, etc. I got out of this meeting that our county medical societies and their component medical member physicians for the most part are not aware of when people are in difficulties with drugs. Then, when they do recognize that someone is having a problem, they, for the most part, are at a loss more or less to know what to do for them. The recommendation was made, and a very good one I think, that they get busy in an educational effort with our physicians.

The next item is the Emergency Medical Services Meeting which was a real bang up one held in the Headquarters building on the 23rd of January. I would like for Dr. Schauwecker to make a little report on that meeting.

DR. SCHAUWECKER: We did have a very interesting meeting with five groups being represented. We had two or three generals; state police; state highway commission, National Guard, sheriffs and others. I would like to say that the Superintendent of the State Police gave a tremendous report. They are going to change their Posts in many areas and they have proposed to have helicopter ambulances in these posts so that when a call does come in, any individual in the state of Indiana would be within 20 minutes of hospital care.

You can't ignore things like some of the presentations made at this meeting. It is tremendous, so I think the future will be to promote the program and to join in.

DR. PETRICH: Thank you. I think two important things and one was that many people who were at the meeting, in fact the physicians who were dealing with their patients directly had come with very definite ideas that the helicopter was absolutely useless, or that it had very limited use and, by the time the meeting was over, several of them said that they had come with that fixed idea and that they were leaving with an entirely different concept

and could see a very valid role for the helicopter in general use for emergency services.

I received a very fine letter from an ex-board member, Dr. Robert Reid, regarding the activities that have taken place in the areas of computers in medicine and it was not a plea for any big contract between his organization and ours. It was a philosophic letter which any of you are welcome to read. It is very well written and very well thought out. The core issue in it is that the Indiana State Medical Association, as a representative body of the practicing physicians of the state, is not and has not done its share and its fair part toward the application of computers in medicine. You know I have been interested in this and in the week-end meeting we had many doctors are interested in it and I think we should take the lead in whatever mechanism we need to follow in order to get some study going or whatever. I think now is the time, and actually the time is long past, and I hope that some action will be forthcoming today.

CHAIRMAN: Thank you, Dr. Petrich.

DR. SCHUSTER: I want to bring to the attention of the Board the meeting to be held April 13-15 in Scottsdale, Arizona, sponsored by the AMA on the subject of Drug Abuse and for representatives of medical societies. I think this is important in terms of medical society understanding and that a representative of the association should be sent.

DR. PETRICH: This was discussed in the Executive Committee meeting last night and the recommendation was made that the member of the commission concerned with this be requested to attend the meeting.

DR. HILLIS: I think along with this discussion about sending someone to that meeting that this organization present some comments of the extension of the drug problem on younger teen-agers in this state. I think all of us can see that younger people in our own business are finding this problem is now reaching down to the place where the people in general are not going to tolerate it much longer. Just this last week I heard a serious discussion, not just a remark, about the formation of a group which approaches the old system of vigilantes in regards to this pushing of dope and marijuana and other narcotic drugs—even almost to the grade school level.

DR. DUKES: If there are no other comments, we will move on to the president-elect, Dr. Gosman.

DR. GOSMAN: My report is brief and short. At the last meeting of the Board



I discussed with you the fact that the Indiana Division of the American Cancer Society is ready to go with their telephone communication thing for physicians throughout the state to call and ask cancer questions and get the answers, and I failed at that time to get approval for the use of the Addressograph so that this could be mailed out to our membership and I now ask for that approval.

DR. DUKES: A motion was made for this approval, duly seconded, to grant the use of the mailing list. Any discussion? If not, those in favor say aye. Opposed same sign. The motion is carried.

DR. GOSMAN: I have visited the county societies of Wabash and Huntington, and I think the most important thing I have come away with from these places is that there is still a lot of non-information or misunderstanding as to what utilization and peer review and foundations are, so that we have an educational process to do here in these particular areas, as I see it. I would like to suggest perhaps consideration be given to some postgraduate courses during the scientific session of our annual meeting, with credit being given to men, since we are talking about continuing the medical education in these areas. I know some other states are already doing this. I would like for it to be not only for general practitioners but for everyone.

I would like to get permission to invite representatives of the Marion County Medical Society to appear before the Board to bring you up to date on the latest developments in the HMO situation in Indianapolis. At the Council meeting of the Methodist Hospital last week two gentlemen appeared. One is the executive secretary of this organization who was brought in from Washington, hired and is running this organization. I think it is time that we all become better informed as to what is really going on and what the status of it is at this time. They hope to set up four centers in this city which will enroll up to 20,000 people on a capitation basis in each one of these and the monies are coming in here and, from what I hear, it is really going to roll. I asked the question—do you anticipate any difficulty in getting physicians to handle this—the answer was “yes.” The next question was—what do you plan to do if you don’t get the physicians? They said “Doctor, if we are offered enough money, we are going to get them; and, secondly, if we don’t get them here, we will bring them in from out of state.” So that is the reason why I am asking that these gentlemen from Marion County be brought up here to bring us up to date as to where we stand.

DR. DUKES: When do you want this done?

DR. GOSMAN: I would like to have this done at the earliest convenience but not today.

DR. DUKES: Do we have any objection to this? All consent then, O.K.

DR. GOSMAN: As you know what transpired in the newspapers this past week, one becomes pretty hot headed at times and I think if we let 24 or 36 hours go by to think it over a little bit, we temper our thoughts. I had a long list of things listed here. I have written two pages and I would like to say to this Board, however, let me boil it down to this point. I think it is about time that we sat down again and go over this entire insurance handling program. I think this gives us a real opportunity to do something for our membership and I think we should take definite steps as to what to do under these circumstances. What do you do under the other circumstances and where is the dividing line and where is the end point? As I sat in and listened in on the Commission on Economics and Insurance and we got into peer review mechanisms, which is also on the agenda here, I am wondering sometimes if the boys from the Anderson area aren’t correct when they say that if a patient comes in with a complaint regarding their bill, they will listen to them; but as far as any insurance company or outside or third party, they will not have a thing to do with them. It has to be generated by the patient. Now I think that at last night’s Executive Committee meeting it was recommended that this be turned over to our Commission of Medical Economics and Insurance, but I do feel that this is a point that we have got to do something for our doctors. Thank you.

DR. DUKES: If there are no further questions, we will move on to Dr. Wood, AMA trustee, who has now entered the meeting.

DR. WOOD: Thank you, Mr. Chairman. May I give a report on several items which I have to discuss. One has been discussed by Dr. Offutt which has to do with the legislature and as you know, I chair the Commission on Legislation. I might say that my impression was the same as Dr. Offutt’s—that this was an exercise in futility—that we had no runs, no hits, no errors and that about sums it up.

The next item has to do with the meeting of the directors of the Medical Education Foundation which met for the allocation of the AMA-ERF funds. I am happy to tell you that the Dean wrote a very fine article in the Alumni Bulletin that was just put out and if you will look

on the righthand side, he discusses this in total giving the amounts and I am glad that the practicing physicians get the credit. I am hopeful that the students recognize this too.

Dr. Wood then reported on plans for his coming Medic-Civics program at the School of Medicine and pointing out that, in his opinion, the tide of activism is turning and that the younger age group is beginning to turn over to a more responsible attitude.

Dr. Wood continued then to outline in detail the program for the Medic-Civics Program.

The next thing is to discuss with you the matters of the Board of Trustees of the Medical Association. The Blue Shield problem, as it appeared in the papers—I notice that we are going to have a special meeting to discuss this problem and they are all aware of it and I am hopeful that there is no over-action to it. It is my own personal opinion, but I think that some sound approach to the problem is going to have to be made and I am sure it will be done.

The next thing is the relation of Dr. Petrich’s comment concerning the computer in medicine. I am happy to tell you that I think there has been some real progress made. No. 1, the HEW has accepted the five digit code and, No. 2, they have accepted CPT, so that this is what the medical profession has been asking for so I think they are going to get that.

Two other things—I think you all noticed that Dr. Gosman has been appointed to the new Cancer Committee of the American Medical Association and the recommendation has been made that Dr. Maurice Glock be put on the Medical Assistance Advisory Committee of the President which has to do with advice so far as Medicaid is concerned. As you know, he is also on the Medical Advisory Committee of the State Department of Public Welfare.

The last item I want to discuss is the Public Affairs Conference, which many of you are going to this week in Washington. At that time I have made request to meet with some of the staff at the White House. We are going to discuss HMOs and I hope that your attitude is the same as mine that HMOs may be all right in some places for some people but certainly any major shift within the health care delivery system should be on a trial basis until such time we have had an opportunity to see how it operates rather than to have it a total legislative procedure such as Medicare and Medicaid, which has been a fiasco. Thank you for your time.

DR. DUKES: Thank you, Dr. Wood.



The press reports on the Blue Shield article were further discussed by Dr. Petrich, Dr. Shields, Dr. Wood and others.

DR. DUKES: We will now call on Mr. Kilborn, President of Blue Shield.

MR. KILBORN: Gentlemen, I asked for the opportunity to come before you today to try to explain what we are trying to do at Blue Cross-Blue Shield of Indiana. This will come up at our next board meeting for discussion. I personally have very strong feelings about this subject as to what I think is fitting and proper. My executive committee has expressed a decision to the board and it will be up for action at the next meeting. As I have told the executive committee and numerous physicians on the board, I personally have my feeling as to what is right and wrong on the subject but when it comes right down to it, it is, of course, going to be their decision as to which way we go. I think there are a few things which should be understood. First of all, the original thought, and it was only held by the consulting firm, was that Blue Cross-Blue Shield should merge totally. I personally indicated to the executive committee that I didn't think it was proper and I didn't think it would work. To understand the role of the board of directors versus the role of the chief executive officer, and for that I would like to refer you to page one of the informational sheet which is being given to you at this time.

Mr. Kilborn then proceeded to go through the handout page by page and discussed the items contained therein before the Board.

There followed a lengthy discussion by several members of the Board and Mr. Kilborn concerning his report. Mr. Kilborn went on to announce that the State Welfare funds were in jeopardy of running out before the fiscal year ends in July. He also pointed out that it might be necessary to pay all purveyors across the board 50¢ on the dollar until the new fiscal year comes in.

DR. GOSMAN: While Mr. Kilborn is still here I would like to thank him for the courtesy of having our own staff review the article and help write the article which appeared in rebuttal to the AP release on the doctors under the Medicare program.

DR. DUKES: Thank, Mr. Kilborn. Now we will have the treasurer's report, Dr. Hoyt.

DR. HOYT proceeded to review the detailed report of the Treasurer's office which was a part of the agenda of the Board. Following a detailed analysis of the report, Dr. Hoyt moved the acceptance of the report.

DR. DUKES: The motion was made by

Dr. Hoyt to accept his report, seconded by Dr. Petrich. Any further discussion? All in favor say aye. Opposed, the same sign. The motion is carried.

DR. DUKES: We will now move on to the editor, Dr. Ramsey.

DR. RAMSEY: Mr. Chairman, gentlemen, Dr. Hoyt pointed out that *The Journal* is losing money less rapidly than it did. The advertising picture is better nationally and the Advertising Bureau is a little more optimistic this year than it has been for a long time. The March advertising of our journal is 25% more than it was a year ago. The Pharmaceutical Manufacturers Association for many years has produced advertisements through their own institutional advertising and has asked various medical journals to publish these free. This has always been done willingly as a matter of good business and a little item of getting along with the people who will eventually determine how much advertising revenue we get from pharmaceuticals. I am happy to announce that, beginning in April, the Pharmaceutical Manufacturers Association will carry three pages of paid advertising in each issue of our Journal.

This concludes my report.

DR. DUKES: Thank you, Dr. Ramsey. We will now move on to matters referred by the Executive Committee.

DR. KERR: Your executive committee met last evening and considered some 65 items, the following of which were referred to this Board.

The first one is a resolution from Delaware-Blackford Society which reads as follows: Dr. Kerr then read the copy of the resolution. Quite obviously this could entail a considerable expense and, as you know, it is required that any resolution calling for the expenditure of funds must carry with it a fiscal note so that the financing of such a resolution could incur expense and could be handled. It is obvious that this would have to go to the House of Delegates for action but it should contain a fiscal note accompanying it before such resolution is presented.

The next matter involves the physicians' Blue Shield rate increase. As you know, you gentlemen have to approve or disapprove this rate increase. Mr. Waggener has received a letter which reads as follows: Dr. Kerr then proceeds to read the letter from Blue Cross-Blue Shield in which it points out that no adjustment in membership fees will be required for account numbers 01-09465, 01-09565, 01-09665 of employer code 903. We wish to announce that the rates for the professional health security plan will have to be increased effective with the policy year

beginning April 1, 1972. This increase, to the best of our knowledge, is well within the guidelines of Phase II. The new rates on the quarterly basis will be: This is with the \$250 deductible—the new rate will be \$31 for a single person—the previous rate was \$28.20. The family rate will be \$71.10—the previous rate was \$63.75. For the \$500 deductible, the single will be \$28.40—previously was \$25.83. For the family the rate will be \$65.30 as compared to \$59.37. While the \$250 and \$500 deductible are the only two plans being offered at the present time, those who are currently enrolled with the \$750 deductible, the single is \$25.70 compared to \$23.36. The family will be \$58.86 compared to \$53.50. For the \$1000 deductible the single will be \$22.78 and the family will be \$51.78 compared to the \$47.08.

They have sent along some additional information to substantiate the increase and, Mr. Chairman, I believe this Board either has to approve or disapprove this new rate proposal.

DR. DUKES: Any further discussion?

The matter was discussed by several.

DR. DUKES: I will refer this to the Liaison Committee and ask them to report back later in the meeting.

DR. KERR: The Executive Committee also approves the report on the Emergency Medical Services and commended them on their activities involved essentially with the matter of a policy relative to the training of ambulance personnel and emergency service. This is a statement which should be jointly issued by the State Medical Association, the Indiana Hospital Association, Indiana Ambulance Association and the Indiana State Board of Health, and if you like I could read it all. Essentially it is just an approval of a training program. Does anyone have any further questions? We have reported it for your information.

Another matter I particularly inspired an investigation on, and this is relative to the question of the physician's liability in drawing blood on the suspected drunk driver. There was a lot of confusion after the Implied Consent Law went through and there were those that thought this implied that the physician was relieved of any liability when this occurred. This is definitely not true. We have a letter from our legal counsel which reads as follows: Dr. Kerr then proceeded to read the letter from the legal counsel, which pointed out that the physician drawing blood under the Implied Consent Law without the consent of the patient was in for possible suit.

MR. WAGGENER: I might say we did propose an amendment to the law to do this but it didn't get anywhere. You know the law the way it is written, when a



person draws blood he has to be certified by the Indiana University School of Medicine State Toxicologist, so all you can do is to make this statement that those people would be immune who have been certified by the State Toxicologist.

DR. KERR: It seems to me that we are now getting a rash of actual or threatened lawsuits for medical defense. This is something we are going to have to watch.

We also considered last night the matter of printing *The Journal*. As you know, we have had difficulty in the timing of this thing. We couldn't get the convention issue out until well after the convention was under way which made it extremely useless. No amount of negotiation and efforts of changing this have so far been successful. Jim has been talking to the people in various other areas who do such things as printing journals and it was the conclusion that it would be best, though it would cost a little more, to go to an outfit in Louisville, Kentucky, who are known to be men of their word to get the book out when they say they will get it out, but before this change was made, it was thought the Board needed to approve it. Jim, would you care to speak on this?

Mr. Waggener then pointed out the difficulty in the publication dates of the Journal and reviewed the history of some of the reprints which have been ordered from the printer but had not been received at the time of this meeting. He pointed out that he had received bids from the Gibbs-Inman Company of Louisville, Kentucky, which does print all the color inserts for the State Medical Journal Advertising Bureau, as well as from the Ovid-Bell Press at Fulton, Missouri. In making an analysis of the cost of the Journal, the base price at Seymour of the November Journal was \$2,768 and the Gibbs-Inman Company at Louisville gave a bid of \$2,839.19. I would estimate that if we went to Gibbs-Inman, I would predict that the over-all for the year would be an increased cost somewhere between five and 10% for the Journal. They do promise us that if we follow the schedule which they have submitted to us, they will have the Journal in the mail by the fourth day of the month.

DR. SHIELDS: Have you discussed this with Seymour? What is their excuse for not producing this earlier?

MR. WAGGENER: I had mentioned that we had them up here sometime ago and they promised to get back on schedule but what the problem is, I don't know. Of course I do understand they lost one of their key employees sometime ago but they have been getting no better since last September.

DR. SHIELDS: You think it is useless then?

MR. WAGGENER: Well I don't know what the reason is. It is a good shop and the people there are all right but for some reason or other they apparently don't have control of production firmly enough. It took us twenty-three days a few months ago to get galley proofs of the scientific articles back which we had submitted to them. This should never take over four or five days.

The matter was further discussed by Dr. Dukes, Mr. Waggener, Dr. Clark and others.

DR. PETRICH: I move that we transfer our printing of *The Journal* to the Gibbs-Inman Company of Louisville as soon as feasible.

The motion was seconded by Dr. McIntosh.

DR. DUKES: A motion has been made by Dr. Petrich, seconded by Dr. McIntosh, that we have our journal printed at the Gibbs-Inman Company in Louisville. Any further discussion? If not, those in favor say aye and, opposed, same sign. The motion is carried.

DR. KERR: One more item for your information. We have a note from the Department of Political Science of IUPUI concerning U. S. Department of State holding a Council on World Affairs in Indianapolis, April 14, 1972. It is to be a Citizens Foreign Policy Conference on the IUPUI Westside campus. We have been invited to send a representative and, if any of you are interested in attending, please notify Mr. Waggener so your name may be sent in. There will be a \$5.00 charge to cover the luncheon and administrative expense. This concludes my report.

DR. DUKES: Thank you, Dr. Kerr.

DR. INGRAM: Mr. Chairman, concerning the first item of Dr. Kerr's report, were you going to have further discussion on that resolution?

DR. DUKES: What do you want to say about it?

Dr. Ingram then explained the thinking behind his county medical society on proposing such a resolution.

The matter was further discussed by Dr. Shields, Dr. Chamberlain, Dr. Santare and others.

DR. DUKES: If there is no further discussion, we will move on to the reports of trustees. The first district is not represented. The second district—Our meeting is scheduled for May 18th in Linton and everyone is invited. I have a request from the Monroe County Society for the remission of dues for two of their members and I so move.

The motion was seconded by Dr. Petrich, put to vote and carried.

DR. GOODMAN: Third District. The 1972 meeting will be held April 5th at the Marriott Motel in Clarksville and, for the information of any of this fine group who may choose to come to the meeting, which is on the same date as those leaving for Florida, there is a flight from Louisville connecting with Florida that leaves at 10:50 with arrival in Miami airport connection about 2:00 a.m.

DR. DUKES: Fourth District, Dr. Shields.

DR. SHIELDS: No report.

DR. DUKES: Fifth District, Dr. McIntosh.

DR. MCINTOSH: The meeting is to be May 24th at the Terre Haute Country Club.

DR. DUKES: Sixth District, Dr. Inlow.

DR. INLOW: The District meeting will be held May 3rd at the Holiday Inn in Shelbyville.

DR. DUKES: Seventh District, Dr. Schuster.

DR. SCHUSTER: I have a request for remission of dues for two members of the Marion County Medical Society and I move their dues be remitted. The motion was seconded by Dr. Santare, put to vote and carried.

I have another item which I would like to bring up. One of the members of our district requested a copy of the opinion of the attorney on Consumer Credit. I had posted this in the hospital and many have indicated that there was confusion from this legal opinion and one doctor was asking for a copy because Mr. Farris, who is the director, apparently expressed the thought that all doctors would come under this registration because they do have patients who do not pay all their bills in four payments. I wonder if it would be possible for the State Society to put it in the next mailing or a News Letter a more simple clarification because it is the opinion of the majority that it actually says that almost everybody has patients who take longer than four payments to pay the bill.

The matter was further discussed by several and Dr. Schuster moved that our legal counsel be requested to investigate this further and give us a further statement to the patient. The matter was further discussed and the motion was lost for want of a second.

DR. DUKES: 9th District, Dr. Sholty.

DR. SHOLTY: No report.

DR. DUKES: 8th District. I am sorry, Dr. Ingram, I missed you.

DR. INGRAM: No report.

DR. DUKES: 10th District, Dr. Santare.

DR. SANTARE: Our meeting has been changed to May 31st and is to be held at

the Lake of the Four Seasons at Hebron and we are going to have Mr. Ed Annis as the speaker and invite as many of the Board of Trustees to come as can.

DR. DUKES: 11th District, Dr. Hillis.

DR. HILLIS: There is some question about the date, whether it will be September 20th or 21st. There is a little problem about being in Kokomo so the committee is working to have William Buckley as speaker.

DR. DUKES: 12th District, Dr. Clark.

DR. CLARK: Our meeting will be on September 14th. There will be a good show up there—even better than last year. Dr. Ed Annis will be our speaker.

DR. DUKES: 13th District, Dr. Gattman.

DR. GATTMAN: No report.

The Board then convened following lunch.

DR. DUKES: We will now have reports from the Board Committees. Dr. Inlow, do you have a report.

DR. INLOW: Sorry, I do not have a report at this time.

DR. DUKES: Dr. Sholty.

DR. SHOLTY: Sorry, I have no report at this time either.

DR. DUKES: Dr. Shields, your report on resolution 71-3.

DOCTOR SHIELDS: I have copies of two resolutions from Jim on this. This is 71-9. Well this is the one I studied, so I do not have a report at this time.

DR. DUKES: Then will you have a report on 71-3 at the next meeting? Dr. Goodman, do you have a report on resolution 71-11.

DR. GOODMAN: This is a report on resolution 71-11. Reporting the action of the House of Delegates, in which they feel that the Association should provide the Commission on Convention Arrangements with adequate funds for the honorarium for speakers at our annual meeting.

I believe the Board has already taken care of this by increasing the appropriation for this purpose up to \$5,000.

DR. DUKES: Thank you, Dr. Goodman. Dr. Gattman, are you ready to report on resolution 71-24?

DR. GATTMAN: Resolution 71-24 deals with the Flow of Illicit Drugs from Communist China and was referred to the Board of Trustees for further study. I move that we approve this resolution for referral to the American Medical Association.

DR. PETRICH: Mr. Chairman, having almost total recall, it seems to me there was a question of substantiation of the factual information that was proposed in the resolves or the whereases that were part of the resolution as presented. Dr. Sholty did appear at the Reference Committee, as I remember, and he had some infor-

mation that was printed but the Reference Committee did not feel that the information was historically as factual as it might be, so they referred it to the Board. Now I think the thing that the Board has to do is to investigate the background information in the Resolution and then determine if the whereases justify the resolves, to put it very simply. I don't think that this has been done now and I don't think we can pass this along to the AMA and look like a bunch of horses without know what it is all about.

The matter was further discussed, and Dr. Hoyt moved that we do nothing with the resolution at the present time, due to the fact that Mr. Nixon has been to China.

DR. DUKES: Dr. Hoyt will you withdraw your motion and then we can just take this as a matter of information.

Dr. Hoyt withdrew the motion and the matter was taken as a matter of information.

DR. DUKES: We are now ready for the report from Dr. Gosman, Dr. Schuster and Dr. Sholty concerning the restoration of the old Pathology Building at Central State Hospital.

DR. SCHUSTER: This has to do with the Museum and the old Pathological Building at the Central State Hospital which is in the process, hopefully, of being restored and becoming a living museum. The State, as I understand, has appropriated \$25,000 for which the building has been re-roofed but then the state withdrew some of the money which leaves the group in a financial situation where they must look elsewhere for funds. As I understand it, Eli Lilly Company has made an offer of a \$10,000 grant, if it is matched, to provide for refurbishing the inside. I was out there yesterday morning at the Explorer Scout Meeting and some 40 young people out there trying to interest them in medicine in general and this place I think has a real place and I think the medical profession should try to help out with it. It is badly in need of refurbishing, because the roof did leak and the inside needs painting and a lot of things need to be done in addition to that. They need to catalog all the different items they had — anatomical specimens; microscopic slides; the archives; for instance, the old pathological reports that were written in hand by the pathologists back at the turn of the century. I think it is a worthwhile project and the question which is raised, of course, was in regard to what the ISMA might do to come up with \$10,000 to match Lilly's offer. Dr. Gosman and I discussed this matter as Bill Sholty was out of the country, and we considered different possibilities; but it

seems the one we would present to the Board was the possibility of using some funds from the AMA-ERF fund at Indiana University. That particular aspect of it I am not entirely clear on, although we know that recently in a discussion with the Dean a certain amount of money was taken from this fund for his use on various projects and perhaps under this same approach that money could be taken from this fund for the aspect of medical education that it does refer to medical education in terms of the students, physicians, and also the general public. It was in that connection that I would refer to Dr. Gosman to tell about this fund, because I am not sure how it all works.

DR. GOSMAN: Well, the other possibility was, of course, to go to the dues structure at the convention again asking for maybe 50¢ or a \$1.00 from each man and we felt at this time we did not wish to do this. We felt on the other fund, it was a perfectly justifiable spot from which to draw the \$10,000 to meet Eli Lilly's offer, in order that they might go ahead with what they would want to do out there.

The matter was further discussed by several and, on motion of Dr. Gosman, it was moved to recommend to the Directors of the Medical Education Foundation that the sum of \$10,000 be granted for this particular purpose. The motion was seconded by Dr. McIntosh.

DR. DUKES: Any further discussion? If not, all in favor say aye. Opposed, the same sign. The motion is carried. Who, then, can call a meeting of the Foundation? Mr. Waggener, will you investigate this and call a meeting as soon as possible.

Dr. Petrich then discussed the matter of membership on the Admissions Committee of the Medical School and this was discussed between him and several others. Dr. Gosman then moved that the Association enter into more discussions with the Dean because he did not make any comment in this area at his appearance before the Board this morning. The motion was seconded by Dr. Inlow, put to vote and carried.

DR. DUKES: We will now move on to Economics and Organization Matters. Before we get into that, does anybody want to place a bid on that grill we had downstairs. Dr. Gosman bid \$100; Dr. Harshman \$150 and I will bid \$175. Who wants to make it \$200? Dr. Harshman offered \$180 and, by action of the chairman, Dr. Harshman was sold the grill for \$180.

DR. DUKES: We will now review the membership report. The report was reviewed and taken by consent.

DR. DUKES: We have a guest, Dr. Isenogle from Ft. Wayne, who has re-



requested permission to appear before the Board.

DR. ISENOGLE: Dr. Isenogle reviewed the history of the proposed merger between Blue Cross and Blue Shield and expressing his opposition to it and, he hoped, the opposition of the Indiana State Medical Association to such a proposed merger.

The report was discussed by Dr. Duker, Dr. Ingram, Dr. Isenogle, and many others.

DR. DUKER: Thank you, Dr. Isenogle, for your remarks. We will now move to unfinished business, the matter of the fee review program proposed by the Commissions on Medical Economics and Insurance and Governmental Medical Services, which was tabled at the meeting on January 9th, upon motion of Dr. Santare. This will require a motion to remove from the table. The motion was duly made, seconded, put to vote and carried to remove the matter from the table for further discussion.

DR. INGRAM: At the meeting of the House of Delegates in South Bend, the state was authorized to establish a Peer Review Committee but, on the other hand, the resolution also provided that this committee would not act unless requested to do so by a county society. Now that was very explicit and I know that it is there and that it is established policy and because of what I think the suggestion in the minutes of the Commission on Medical Economics and Insurance and the Governmental Medical Services Commission is strictly against the established policy of the House of Delegates and should not be done unless it goes back to the House.

The matter was discussed by many, it being pointed out that, in the report of the Commissions, they said that if the state should set up a Review Committee the three following things would be specific: (1) That the decision of the Review Committee would be final with the Insurance Company and there would be no other place they could take this. (2) That the request should come only from the county society involved. And would accept cases only and only if the County requested. (3) That they would set up rigid guidelines for all procedures. These are the three things that the Commission recommended.

Further lengthy discussion ensued.

DR. DUKER: We will read the Resolution as adopted by the House of Delegates.

The Resolution was then read in its entirety. Now, Dr. Ingram, will you restate your motion?

DR. INGRAM: I would like to amend it to read as a substitute motion: "I move that the Medical Review Committee of the Indiana State Medical Association, in keeping with the policy established by the House of Delegates of ISMA in 1969, function only at the request of and to lend assistance to County Medical Review Committees."

The motion was seconded by Dr. Inlow.

The motion was then discussed by many.

DR. DUKER: Is there no further discussion? All those in favor of the motion say aye and, opposed, same sign. The motion was carried.

We will now move to item M—new business.

DR. SANTARE: I went over the information from Blue Cross-Blue Shield concerning the proposed rate increase effective April 1, 1972, in the major medical program with Dr. Hoyt and Mr. Kilborn. After reviewing this matter, unless someone else can find something else different, I move that we accept the increase in fees.

DR. DUKER: The motion has been made by Dr. Santare to accept the increase in fees. Seconded by Dr. Shields. There being no further discussion, all those in favor say aye. Opposed, nay. The motion is carried.

DR. DUKER: We will now move to the item of Dr. Owsley's campaign for election as vice president of the American Medical Association.

DR. PETRICH: We have ordered 300 of the ceramic owls at a cost of \$600, as it takes 288 to cover the House of Delegates of the AMA. It was felt in the Executive Committee last night that this will be a popular item to draw a lot of other people into the Indiana camp and it was recommended that we order an additional 200 @ \$1.75 each. So that is where we stand at the present moment. This is the gift we plan to give away at the Hospitality Room and to the delegates at the AMA.

The matter was discussed by several.

DR. PETRICH: Mr. chairman, in view of the fact we have ordered 300 of these, I think it would be a little asinine to back off with the 300 and if you are going to do it, do it right. Therefore, I move that we add another 200 at \$1.75 each.

DR. DUKER: Dr. Petrich has moved that we order another 200. The motion has been seconded by Dr. Clark. There being no further discussion, all those in favor say aye. Opposed, same sign. The motion is carried.

The method of distribution of the ceramic owls was then discussed by several. One suggestion was made that, rather than buying the additional owls, we buy some stickers for badges and, upon motion of Dr. Santare and seconded by Dr. Ferrara, it was moved to reconsider the previous action and the motion was lost.

DR. PETRICH: I move then we spend the other \$50 to buy stickers to put on the badges. Seconded by Dr. McIntosh, put to vote and carried.

DR. DUKER: Any other business to come before the Board?

DR. MCINTOSH: I would like to make a motion to have the executive secretary ascertain from our legal staff their opinion how the M.D.s could be protected from a lawsuit arising from the usual and customary fee concept and report back to this meeting. This has to do with what Jim Harshman was talking about awhile ago. The doctor had sent in the usual and customary fee which hadn't changed from over a year or so but he got a notice back that this was how much the insurance company was going to settle for and if the doctor tried to do anything about it by law if they could sue.

DR. PETRICH: May we editorially amend this to specifically include an inquiry into the Motors contract and Resolution 26 and how it applies to individuals rather than to the Society.

DR. DUKER: A motion has been made by Dr. McIntosh and amended, with consent, by Dr. Petrich and has been seconded by Dr. Shields. If there is no further discussion, all those in favor say aye and, opposed, the same sign. The motion is carried.

DR. DUKER: There being no further objections, the Board will meet on June 10th at 6:00 p.m. in the evening with the AMA delegates and will resume the regular Board session at 8:30 a.m. on Sunday morning, June 11th. If there is no other business, I will accept a motion to adjourn.

A motion was duly made and seconded and the Board adjourned. ◀

EXECUTIVE COMMITTEE

April 6 and 7, 1972

Roll call showed the following present: Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Peter R. Petrich, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Jas. A. Waggener. Vincent J. Santare, M.D., was a guest.

MINUTES OF THE MEETING held March 4th were approved on motion by Dr. Gosman and Dr. Petrich.

THE MEMBERSHIP REPORT was approved by consent.

Membership Report:

Number of members as of	
December 1, 1971	4,557
1972 members as of	
February 29, 1972:	
Full dues paying	
members	3,613
Residents and interns	39
Senior	382
Board remitted	50
Honorary	3
Military	29
Total 1972 members as of	
February 29, 1972	4,116
Total 1971 members as of	
April 30, 1971	4,366
Number of AMA members as of	
April 30, 1971	4,118
Number of AMA members as of	
February 29, 1972	3,828
Full dues paying	3,367
Exempt, but active	461
	3,828
Number who paid state dues	
but not AMA dues as of	
February 29, 1972	288

Treasurer's Report

The Treasurer not being present, there was no treasurer's report.

Organization Matters

LETTER FROM VANDERBURGH CO. MEDICAL SOCIETY—A letter from the Vanderburgh County Medical Society informing the association that the Board of Directors of that county had requested that ISMA not hold its 1974 convention in Evansville was read and, on motion of Dr. Petrich and Dr. Gosman, the executive committee is to refer this matter to the Board with the recommendation that the 1974 meeting be held in Indianapolis.

LETTER FROM INDIANA HOSPITAL ASSOCIATION—A letter from the IHA concerning plans for the annual Administrator—Chief of Staff—Trustee Institute to be held at the Columbia Club in Indi-

anapolis on May 10 was read and was taken as a matter of information.

TRAVEL INSURANCE INCREASE—A proposal from Travelers to increase the coverage on the travel insurance for commission and committee members and officers of the association traveling on business of the association and to increase the limit from \$50,000 to \$100,000 for accidental death or dismemberment—on motion of Dr. Gosman and Dr. Petrich, the increase was approved.

MEMBERSHIP IN U.S. CHAMBER OF COMMERCE—Renewal of membership in the U.S. Chamber of Commerce was approved on motion of Dr. Gosman and Dr. McIntosh.

LETTER FROM TEXAS MEDICAL ASSOCIATION—A copy of a letter from the Texas Medical Association addressed to the various members of Congress from their association objecting to the fraud statement printed on checks for Medicaid and Medicare was reviewed and the secretary was instructed to advise the Texas Medical Association that they would support them in this effort. The action was by consent.

BLUE SHIELD-BLUE CROSS COVERAGE EMPLOYEES—Renewal of Blue Shield and Blue Cross coverage for the employees of the Indiana State Medical Association was approved on motion of Dr. Gosman and Dr. McIntosh.

LETTER FROM A. H. ROBINS CO.—A letter from the A. H. Robins Company offering \$200 to the association to be used as it saw fit in development of professional or scientific matters was read and the offer was accepted on motion of Dr. Dukes and Dr. McIntosh.

By consent it was then agreed to refer this matter to the Board of Trustees for their concurrence or rejection of the acceptance and their recommendation as to use of these funds, if accepted.

LETTER FROM ATTORNEY ON INTRAV—A letter from the attorney concerning the contract from Intrav was reviewed and, inasmuch as the federal regulation was not sent to the attorney, it was suggested that the secretary arrange a meeting between the attorney and the Intrav people to resolve these questions.

Convention Matters

GUESTS FOR PRESIDENT'S DINNER—The guests to be invited to the President's Dinner for the 1972 meeting was approved as being the same as for the year 1971 with the addition of the Iowa State Medical Society.

FIFTY YEAR CLUB RESPONSE—No action was taken on selecting the individual for the 50 Year Club response pending

further investigation.

Medical Defense

The secretary reported he had received a schedule of fees from the attorney in the defense of a case against an ISMA member, and this was taken as a matter of information.

An application for medical defense, together with the bill for the attorney's charges for a case previously tried and settled, was presented to the committee. Inasmuch as the application for defense had not been approved prior to the case being held and settled, on motion of Dr. Petrich and Dr. Gosman, this matter is to be referred to the trustee for investigation and report at the next meeting.

A discussion ensued then concerning the amount of money to be paid in medical defense cases, and, on motion of Dr. Petrich and Dr. Dukes, it was voted that a resolution should be prepared for presentation to the Board of Trustees for their referral to the House of Delegates setting a limit of \$2,000 per case and any additional sums would have to be further negotiated between the physician involved and the Medical Defense Committee.

Journal

The secretary reported concerning the action of the last meeting of the Board of Trustees approving the change of printers for The Journal and a controversy which has ensued between one of the members of the Board, the printer and the headquarters office concerning this recommended change.

On motion of Dr. Gosman and Dr. McIntosh, this matter is again to be referred to the Board of Trustees for clarification for the record.

Dr. Petrich requested that he be recorded as abstaining from voting.

The request of Realty Enterprises for space in The Journal was turned down by consent.

A request of the International Market Consultants for space was turned down by consent.

The request of the Casualty Indemnity Exchange for space in The Journal was approved by consent.

The secretary then discussed various methods of preparing the Roster issue of The Journal and gave a quotation from the computer people and by consent it was agreed that the method of preparing the Roster would not be changed at this time.

Future Meetings

Notice of the 13th Annual Conference of United Foundations for Medical Care, to



be held at Yosemite National Park May 7-10, was reviewed and, on motion of Dr. Dukes and Dr. McIntosh, no representative will be sent.

## New Business

A letter from the Allen County Medical Society requesting two members of their society be excused from dues because of ill health and retirement was reviewed and, by consent, the committee took no action upon this request inasmuch as they have no authority to do so under the Constitution and Bylaws, this being solely the right of the Board of Trustees.

A letter from the Allen County Medical Society concerning the ISMA legal counsel's opinion concerning the drawing of blood under the Implied Consent Law and asking for further clarification was read. It was the opinion of the executive committee that the letter was very clear and explicit and that this should be published in *The Journal*.

A letter from the Indiana Hospital Association was read regarding a proposed meeting with HEW officials and a tentative date of June 1st was suggested. Dr. Petrich and Mr. Waggener will attend the meeting to be held at I.H.A. Headquarters.

A letter from David Spolyar concerning the use of the mailing list for mailing certain material to the members of the association was approved by consent.

A memo concerning the cost of owl patches for use at the San Francisco meeting was discussed and, by consent, it was agreed that the secretary be authorized to order 500 of these.

Dr. Santare then appeared before the committee and presented a letter written by a Dr. Goldenberg concerning the recent legal action regarding the right of disclosure of medical records and the method of handling these records.

The secretary pointed out that the system enunciated in the letter, in his opinion, was not the system being used in the State of Indiana and he was asked to further check this matter and report upon it at the next meeting of the committee.

## Next Meeting

There being no further business, the committee adjourned to meet again at 2:00 p.m., June 10, 1972, at the Headquarters building.

## EXECUTIVE COMMITTEE

April 18, 1972

Roll call showed the following present:

Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Peter R. Petrich, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, Jr. M.D., and James A. Waggener.

MINUTES OF THE MEETINGS held April 6 and 7 were approved as circulated, on motion of Dr. Petrich and a second by Dr. Dukes.

## Treasurer's Report

The treasurer's report was approved on motion of Dr. Hoyt and Dr. Petrich, with the recommendation being made to the treasurer that the present treasury bills which will mature within the next few days should be reinvested in 90-day-or-better treasury bills.

## Organization Matters

LETTER FROM RICHARD E. WEIMER—A letter from Richard E. Weimer addressed to the Ball Memorial Hospital and its medical staff was reviewed. By consent, the fieldman is to be asked to check on this matter.

LETTER FROM HAMILL, PRICE & CARROLL—A letter from Hamill, Price and Carroll concerning certain stipulations in the trial of ISMA vs. State Board of Tax Commissioners was reviewed and, on motion of Dr. Petrich and Dr. Dukes, the wording of the stipulations is to be left to the attorney and the executive secretary.

LETTER FROM TIPPECANOE COUNTY MEDICAL SOCIETY—A letter from the Tippecanoe County Medical Society submitting for legal opinion proposed bylaws for the Lafayette Medical Education Foundation, Inc., was reviewed and, on motion of Dr. Dukes and taken by consent, the society is to be advised

that they should have their local attorney check the bylaws.

LETTER FROM VIGO COUNTY MEDICAL SOCIETY—A letter from the Vigo County Medical Society asking certain questions concerning confidentiality of patients' records and the right of third parties to review these records was read and, on motion of Dr. Petrich and Dr. McIntosh, the secretary is instructed to obtain additional information and then procure a legal opinion on this request.

THIRD HOUSE GOLF TOURNAMENT—An invitation for the association to participate in a Third House Golf Tournament was turned down on motion of Dr. Dukes and Dr. Petrich.

LETTER FROM AACHP—An invitation to join the American Association for Comprehensive Health Planning was turned down on motion of Dr. Gosman and Dr. Petrich.

MINUTES OF COMMISSION ON MEDICAL EDUCATION & LICENSURE—The minutes of the meeting of the Commission on Medical Education and Licensure of December 19th in which the commission requested a legal opinion concerning liability insurance for interns and residents was reviewed and, by consent, it was agreed to reply to this request that interns and residents should purchase their own liability insurance and not to refer this to legal counsel for an opinion.

INDIANA JEFFERSON-JACKSON DAY DINNER—CONRAD FOR GOVERNOR DINNER—FRIENDS OF RAY MADDEN—An invitation to contribute to the Indiana Jefferson-Jackson Day Dinner; the Conrad-for-Governor Dinner and Friends of Ray Madden were all turned down by consent, inasmuch as the corporation cannot make such contributions.

INDIANA CONVENTION CENTER—An invitation from the Indiana Convention Center to purchase tickets for a Civic Dinner during the grand opening festivities was reviewed and Dr. Petrich moved that two tickets be purchased for this event but the motion died for lack of a second. There being no further business, the meeting was adjourned. ◀

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NEW ULTRA-MODERN medical building has 3 suites available for immediate occupancy. Desirable especially for ophthalmologist, radiologist, E.N.T., O.B., Gyn., Pediatrician, family practice. Pharmacy next door. All utilities included except phone. Write J. A. Torrella, M.D., Torrella Medical Building, 5324 West 16th Street, Speedway City, Indiana 46224, or phone collect, 317-244-5942 or 317-244-4578.

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## 15 PHYSICIANS NEEDED

ALL SPECIALTIES AND GPs, TO \$50,000 PER YEAR. Normal hours, excellent fringe benefits, ideal family living conditions, locations in Indiana. Send curriculum vitae or call: John W. Brill, area code 317, 547-9595, Brill Personnel, Inc., 4000 Meadows Drive, Suite 102, Indianapolis, Ind. 46205.

WANTED—Full time GP with prospects of membership in corporation in a growing town in northwest Indiana. If interested please submit resume. Salary open. South County Medical Corporation, 13963 Morse St., Cedar Lake, Ind. 46303, 219-374-5431, M. J. Whelan, Administrator.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220.

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WANTED — Physician interested in industrial medicine for rapidly growing industrial clinic in Indianapolis. Reply Box 372.

SOUTH BEND, IND.—General practitioner's office for rent, fully equipped, air-conditioned, active practice. Mrs. Harry Ludwick, 1324 Black Oak Dr., ph. 234-5696. Office is at 2730 Lincoln Way West.

CLINICAL DIRECTOR (PSYCHIATRY) MILWAUKEE COUNTY MENTAL HEALTH CENTER—We are a community orientated center providing out-patient, in-patient and partial hospitalization for adults and children, and also providing community psychiatric clinics located in 6 catchment areas. Supervise psychiatric, neurological, medical and related services. Requires completion of approved 3-year residency in psychiatry, eligibility for Wisconsin license and a total of 7 years' experience or training in psychiatry. For further information contact: George E. Currier, M.D., Asst. Director, Mental Health 9191 Watertown Plank Rd., Milwaukee, Wis. 53226, (414) 258-2040, Ext. 3441.

PART OR FULL TIME physician wanted for Indiana Rehabilitation Services. Please contact Mr. Walter J. Penrod, phone 317-633-7946, or write same at 17 W. Market St., 1028 Illinois Bldg., Indianapolis 46204.

MEDICAL PARTY RECORD—Indiana's own medical singing group in "Songs of Medicine and Med School" — 33-1/3 LP quality recording. 20 bawdy songs bring back memories, \$5.25 postpaid. Larry M. Davis, M.D., 803 Riverside Drive, Newport News, VA 23606 (703) 596-3625.

WANTED: ANESTHESIOLOGIST Board Eligible or Certified; 300-bed community hospital, early fee-for-service partnership, busy practice. Write or call collect: John A. Short, M.D., Box 251, Richmond, Ind. Tel.: 317-966-6444.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (products, services, etc.) (i.e., firms selling brand

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00  
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month  
PRECEDING month of issue.



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# The JOURNAL

OF THE INDIANA STATE  
MEDICAL ASSOCIATION

August 1972  
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Indiana

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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

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Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their pre-disposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

*Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

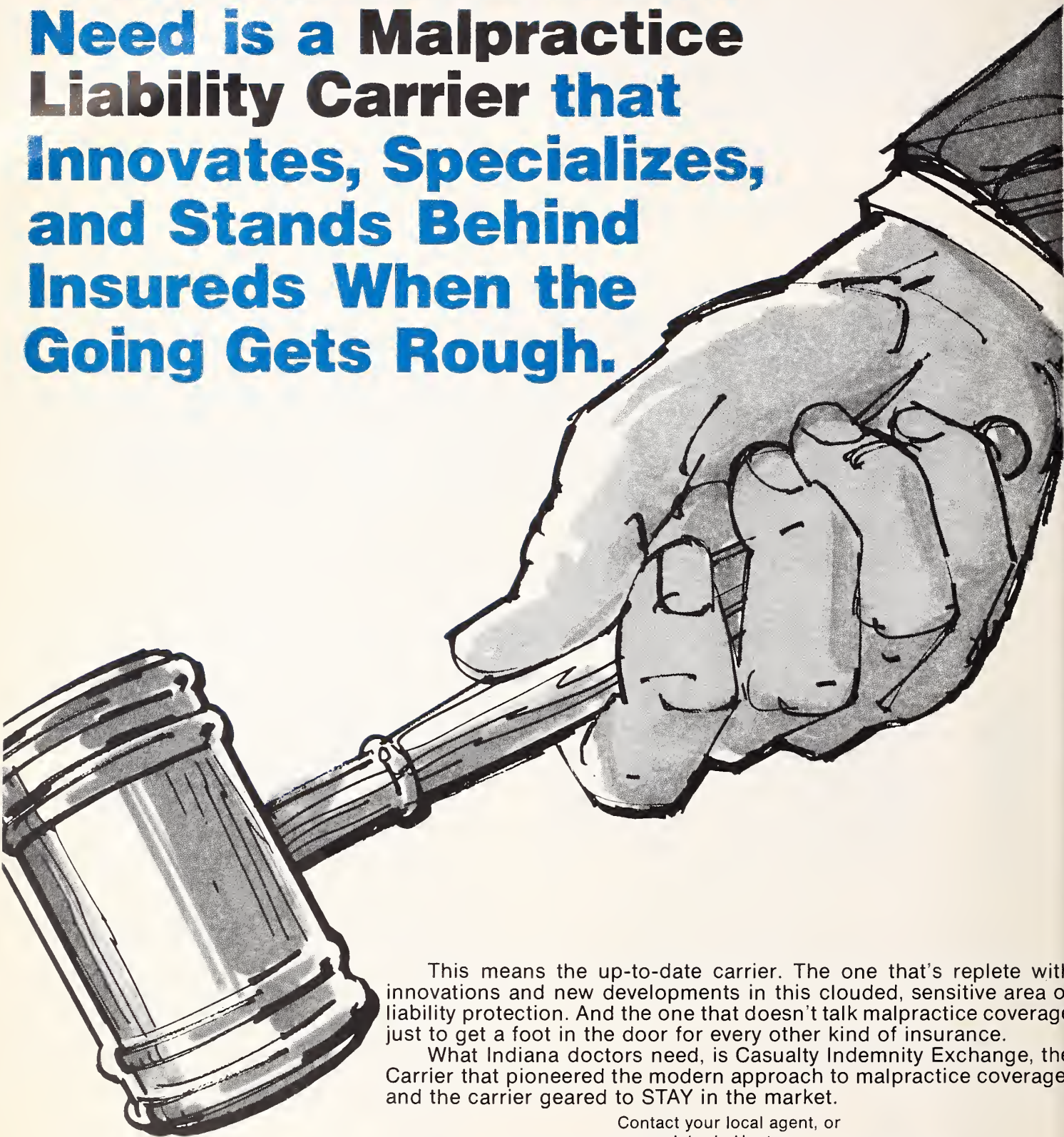
**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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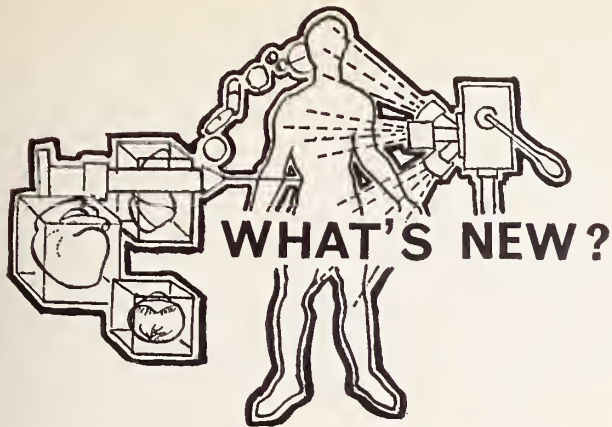


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## WHAT'S NEW?

The Second Edition of "Teaching About Vision" is available from the National Society for the Prevention of Blindness. It has been extensively revised to provide all school personnel with what they have to know to teach a curriculum on vision. It is recommended as a reference for allied health specialists, nurses, nutritionists and physical educators. It sells for \$2.00 per copy. A special discount of 20% is available on all prepaid orders of five or more copies on one order.

\* \* \*

Jayco Products has a rehabilitative and exercising device called KNEE-LIFE. It is a two-way resistance device which straps to the knees. It has a variable tension control and provides resistance for exercising the lateral motion of the knees. In another position it may be used to strengthen the quadriceps and hamstring muscles. It is said to strengthen a normal knee and reduce injuries, and is also useful to rehabilitate injured and operated knee joints.

\* \* \*

Mead Johnson announces plans to market PERISTIM FORTE® (Casanthranol). The drug is a stimulant laxative which increases peristalsis of the large intestine without griping and purging.

\* \* \*

Bunting Sterisystems has developed a new metering device which can detect and measure minute amounts of electrical leakage from all types of electrical and electronic equipment. It is recommended for use in hospitals for detection of micro-shock hazards. It can be hand-carried, operates on penlight batteries and is completely safe within itself.

\* \* \*

Physicians Planning Service Corporation and Associates Marketing Services have formed a nationwide financial service to loan money to physicians and dentists. The new program will cover automobile financing, equipment purchase finance and lease plans, real estate "front end" financing, business loans such as acquisition of laboratories, other professional practices, apartment houses and other equity financing, and unsecured general purpose loans. The new company is called Associates Corporation of North America.

\* \* \*

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



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EDITORIAL AND  
ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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Indexed in Hospital Literature Index.

About Our Cover  
on page 886





## rheumatoid arthritic blowup...

# Tandearil<sup>®</sup> Geigy

oxyphenbutazone NF

tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

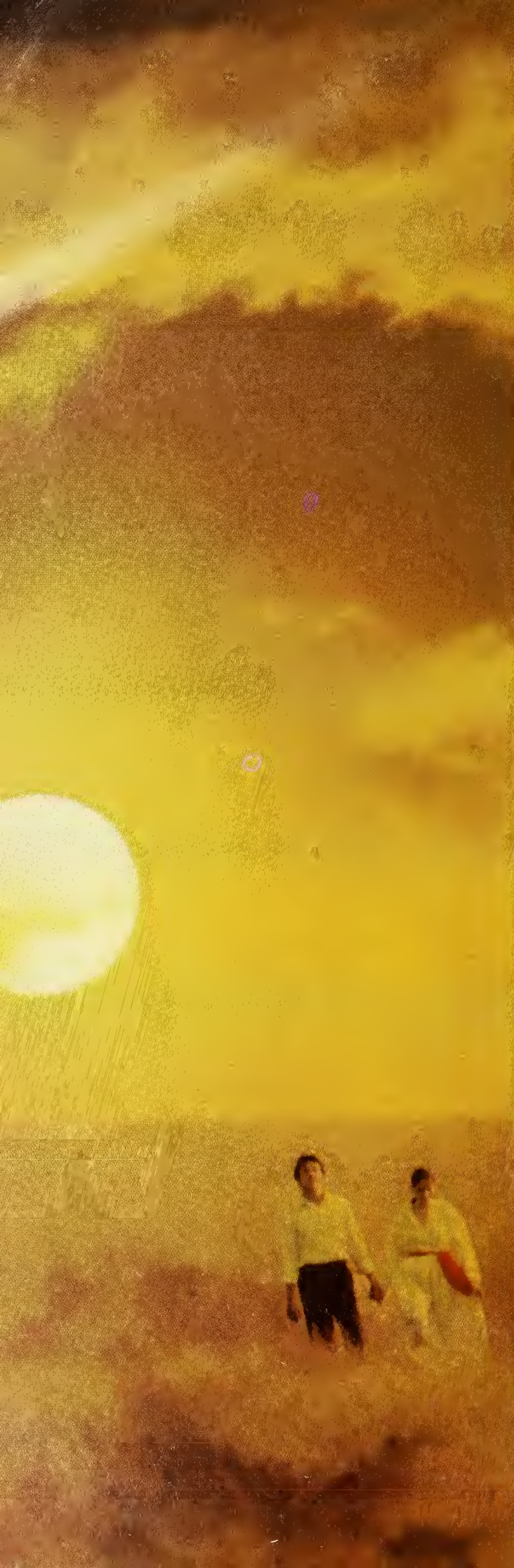
**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B) 98-146-800-E

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Indianapolis, Indiana







This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

THE 1972 DEMOCRATIC campaign platform calls for establishment of a federally-administered, comprehensive national health insurance system to cover all Americans and to incorporate eventually all federal health programs.

THE MAJORITY of the Democratic platform committee proposed that the system be financed by the federal government. A minority wanted it financed under social security.

THE HEALTH CARE PLANK was hammered out by Democratic policy makers in Washington prior to the presidential nominating convention in Miami Beach. Several positions, including the stand on Health Maintenance Organizations, in the health care plank were similar to those of the American Medical Association.

HEALTH CARE parts of the platform proposed by the majority of the drafting committee include:

#### HEALTH CARE

GOOD HEALTH IS the least this society should promise its citizens. The state of health services in this country indicates the failure of government to respond to this fundamental need. Costs skyrocket while the availability of services for all but the rich steadily decline.

WE ENDORSE the principle that good health is a right of all Americans.

AMERICA HAS a responsibility to offer to every American family the best in health care wherever they need it, regardless of income or where they live or any other factor.

TO ACHIEVE THIS GOAL the next Democratic administration should:

- Establish a system of universal national health insurance which covers all Americans with a comprehensive set of benefits including preventive medicine, mental and emotional disorders, and complete protection against catastrophic costs, and in which the rule of free choice for both provider and consumer is protected. The program should be federally financed and federally administered. Every American must know he can afford the cost of health care whether given in a hospital or a doctor's office;
- Incorporate in the national health insurance system incentives and controls to curb inflation in health care costs and to assure efficient delivery of all services;
- Continue and evaluate Health Maintenance Organizations;
- Set up incentives to bring health service personnel back to inner-cities and rural areas;

Continued



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

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3—Eli Goodman, Charlestown	Oct. 1973
4—Howard C. Jackson, Madisan	Oct. 1974
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10—Vincent J. Santare, Munster	Oct. 1974
11—Lawell Hillis, Laganspart	Oct. 1972
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

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11—James A. Harshman, Kokomo	1974
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Fort Wayne	Van Buren
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Terms expire December 31, 1973:

Delegates	Alternates
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Hammond	Hammond

## 1971-72 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Bernard B. Rosenblatt, Evansville	Jahn Winebrenner, Evansville	
2.		J. S. Brown, Carlisle	Bloomington
3.	Claude J. Meyer, Sellersburg	Charles X. McCalla, Paoli	
4.	Kenneth Schneider, Columbus	C. David Ryan, Columbus	Columbus
5.	James C. Lett, Greencastle	J. Franklin Swaim, Rockville	May 23, 1973, Greencastle
6.	Jahn Maennig, Greenfield	Davis W. Ellis, Jr., Rushville	Rushville
7.	Donald E. Stephens, Indianapolis	M. O. Scamaharn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	June 7, 1973, Muncie
9.	Don W. Boyer, Lebanon	Clarence G. Kern, Lebanon	
10.	Lambra Dimitraff, Hammond	Maria D. Mansueta, Munster	May 30, 1973, Hebran
11.	John Elleman, Kokomo	Fred Paehler, La Fontaine	Sept. 20, 1972, Kokomo
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	September 14, 1972
13.	Frank McGue, Michigan City	David L. Spalding, Mishawaka	Sept. 13, 1972, Michigan City

- Continue to expand community health centers and availability of early screening diagnosis and treatment;
- Provide federal funds to train added health manpower, including doctors, nurses, technicians and para-medical workers;
- Secure greater consumer participation and control over health care institutions;
- Expand federal support for medical research including research in heart disease, hypertension, stroke, cancer, sickle cell anemia, occupational and childhood diseases which threaten millions and in preventive health care;
- Eventual replacement of all federal programs of health care by a comprehensive National Health Insurance System;
- Take legal and other action to curb soaring prices for vital drugs, using anti-trust laws as applicable and amending patent laws to end price-raising abuses, and require generic-name labeling of equal-effective drugs; and
- Expand federal research and support for drug abuse treatment and education, especially development of non-addictive treatment methods.

ON BIRTH CONTROL

—FAMILY PLANNING services, including the education, comprehensive medical and social services necessary to permit individuals freely to determine and achieve the number and spacing of their children, should be available to all, regardless of sex, age, marital status, economic group or ethnic origin, and should be administered in a non-coercive and non-discriminatory manner.

ON RIGHTS OF VETERANS

—MEDICAL CARE: The federal government must guarantee quality medical care to ex-servicemen, and to all disabled veterans, expanding and improving Veterans Administration facilities and manpower and preserving the independence and integrity of the VA hospital program. Staff-patient ratios in these hospitals should be made comparable to ratios in community hospitals. Meanwhile, there should be an increase in the VA's ability to deliver out-patient care and home health services, wherever possible treating veterans as part of a family unit.

WE SUPPORT future integration of health care for veterans into the national health care insurance program, with no reduction in scale or quality of existing veterans care and with recognition of the special health needs of veterans.

THE VA separate personnel system should be expanded to take in all types of health personnel, and especially physician's assistants; and VA hospitals should be used to develop state medical schools and area health education centers.

THE VA SHOULD also assume responsibility for the care of wives and children of veterans who are either permanently disabled or who have died from service-connected causes. Distinction should no longer be made between veterans who have seen "wartime," as opposed to "peacetime," service.



# COUNTY MEDICAL SOCIETY DIRECTORY

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FOR THE ELDERLY

ESTABLISH federal standards and inspection of nursing homes and full federal support for qualified nursing homes;

PENDING A FULL national health security system, expand Medicare by supplementing trust funds with general revenues in order to provide a complete range of care and services; eliminate the Nixon Administration cutbacks in Medicare and Medicaid; eliminate the part B premium under Medicare and include under Medicare and Medicaid the costs of eyeglasses, dentures, hearing aids, and all prescription drugs and establish uniform national standards for Medicaid to bring to an end the present situation which makes it worse to be poor in one state than in another.

BEFORE the platform was drafted, two of the Democrats' big guns on health care in Congress appeared jointly for the first time at a platform subcommittee pre-drafting hearing in St. Louis. They were Rep. Wilbur D. Mills of Arkansas and Sen. Edward M. Kennedy of Massachusetts. They showed themselves together in support of a broad national health insurance but still were not in agreement over how it should be financed and administered.

THE PLATFORM committee accepted Kennedy's views on these two points but Mills' ideas probably will carry more weight when Congress gets around to taking up such legislation.

"THE FEDERAL government should establish a system of compulsory national health insurance which covers all Americans with a standard, comprehensive set of basic health insurance benefits supplemented by protection against catastrophic costs," said the Mills-Kennedy statement which included four "freedom guarantees":

- The federal government should not own and operate the various elements of the health care system.
- The federal government should not remove the freedom of every physician and every patient to choose where and how they will give or receive health care.
- Neither the federal government, nor any of its agents, shall make any medical judgments in a patient's care; this function is reserved solely to the physician and his peers.
- The federal government shall not make community health policy but shall offer financial and technical support and information and guidelines based on national planning to support local policy formulation.

URGES PLAN BE FEASIBLE AND FINANCIALLY RESPONSIBLE

DR. JOHN R. KERNODLE, then vice chairman (now chairman) of the AMA Board of Trustees, urged that any national health insurance program supported by the Democratic party be feasible as to benefits, financially responsible and be built on the present proven system of health care delivery.

"IN CONSIDERING any proposal for national health insurance, it is important that several factors receive a careful evaluation," Dr. Kernodle said. "First, the program must be feasible in terms of services offered



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and promises made. It should not hold out promise of benefits which cannot be fulfilled. We urge that any program should be financially responsible, so that public funds are utilized principally to provide financial assistance to those individuals who cannot finance their own medical care through their personal resources. The adoption of any national health insurance plan which undertakes the total medical care of everyone, regardless of their financial circumstances, and does this at public expense, is unwarranted. We would further urge that any plan which is adopted by your Committee also incorporate the use of those private institutions and those private resources and those proven methods of health care delivery which have provided to the people of the United States high quality medical care. Any plan should build on those strengths of the present system and be the means by which a new era of good health and productivity is ushered in for the American people. . . .

“THE PHYSICIANS of America have always maintained that high quality medical care should be available for all Americans, including those who need financial assistance in meeting the cost of such care. We believe that the public health care dollar is used most effectively when it is applied principally for the benefit of those individuals and families whose financial circumstances preclude them from acquiring health insurance protection from their own funds. We believe strongly that to a maximum degree possible any national health insurance program should utilize those mechanisms which have proved themselves to be beneficial in the provision of care to private patients. At the same time we favor experimentation, innovation, and the trial of multiple alternative methods for health care delivery to promote the evolutionary development of productive and viable systems of health care appropriate to the needs of a variety of communities.

“WE BELIEVE that this policy of providing most financial help to those who require help and to permit them the dignity of private care is best incorporated in a proposal which was written by the medical profession known as Medigap and which has been sponsored by 172 members of the present 92nd Congress. This program, using tax credits, enables all individuals to acquire the type of health care services they prefer. It provides a uniform level of benefits—comprehensive in scope.”

#### McGOVERN'S VIEWS OUTLINED

SEN. GEORGE McGOVERN of South Dakota, who all but tied up the Democratic nomination for president before the party's convention, recently outlined his views on health care in a Senate speech which could be termed his “white paper” on the subject.

“THE NATION'S health care system is in critical condition,” McGovern said.

“OVERALL, it costs about \$70 billion a year in private payments and public taxes. “BUT IT IS NOT delivering the treatment Americans need, when they need it, where they need it, and at prices they can afford.

“AND IT IS falling far behind in recruiting and training the people we must have to preserve the nation's health in the future . . .

Continued

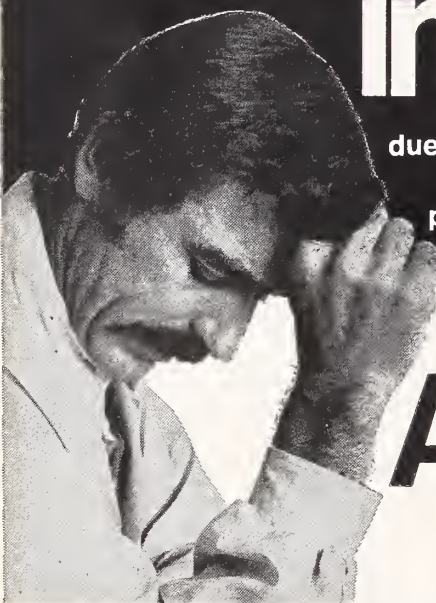


“THE FEDERAL government cannot and should not attempt to solve all health problems by itself. It cannot do the work of state and local governments, doctors and other health personnel.

“BUT CERTAINLY it must take the leadership role in medical care. It is the federal government’s ultimate responsibility to assure the health and welfare of the American people.”

HE PROPOSED FIVE “new directions to help fulfill” that federal obligation:

- “First, we must adopt legislation to insure against the spiral in health bills borne by the individual . . .
- “Second, we should greatly improve the organization and efficiency of the entire health delivery system . . .
- “Third, emergency medical services should be dramatically improved . . .
- “Fourth, medical services must be delivered to areas of acute shortage, particularly in rural areas and central cities . . .
- “Fifth, action is needed to stem the rising cost of drugs.”




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100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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**References:** 1. Montesano, P., and Evangelista, L. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tietoff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradley, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androstosterone. J Clin Endocr 19:1830, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25), Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

**No, it would not be useful.**

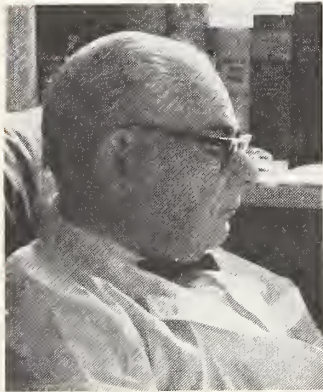


# Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug a patient wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. As I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the "drug of choice" in all areas of medical practice.



# Maker of Medicine

nneth G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Eli Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, and then it will be based on his experience with this drug and his knowledge of the individual patient who is seeking treatment. If an evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a great disservice to medicine and thus to the patient and the consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at the time the new drug would be labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. After, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

What is your opinion, doctor?

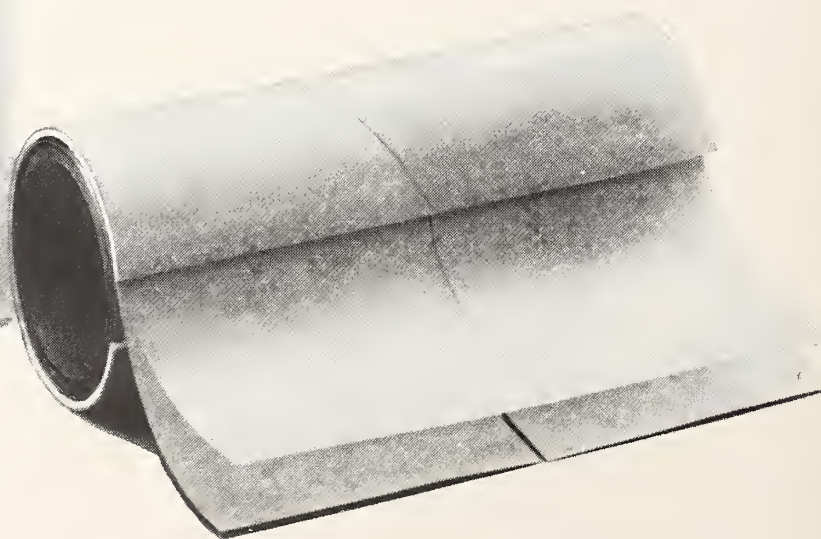
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## The Miracle Workers

GRETCHEN WOLFRAM  
Indianapolis\*

IN the halcyon days of 1921, the “war to end all wars” was finally over, the United States was trying to return to “normalcy” under President Harding, King George V was in the 11th year of his reign over the British Empire, Pius XI was Pope and the boisterous, “roaring twenties” were just around the corner.

Up in Toronto, Canada—in that summer of 1921—two serious-minded young men were turning their attention to the cause of diabetes. All they had was an idea.

There was no massive research grant from a multimillion-dollar foundation or benevolent fund, no air-conditioned laboratories to ease the heat in hot and cramped labs, no staff or help to aid in chores like cleaning animal cages. Just two young men at the University of Toronto who thought—how brash of them!—that there was a possibility of finding the key to diabetes mellitus, a killer disease that had been up to its dreadful business for at least 3,400 years.

Put simply, diabetes results from

the inability of the body to use certain foods normally. The diabetic needs insulin, an internal secretion of the pancreas, to use certain foods, like sugars and starches, which the normal body converts to energy.

Before the insulin discovery, the only advice for diabetics was “severe dietary control.” This usually meant starvation, and that’s hardly a cure or a control.

### In 3000 Years—Only Clues

Others had come close to discovery. There were clues, but all the knowledge that had accumulated for more than 3,000 years failed to offer any more than clues.

Scientists knew there had to be a substance like insulin, but it had yet to be discovered. It took the two young men just a little more than two months to find it. Their names were Frederick Grant Banting and Charles Herbert Best.

Fred Banting, farm boy, was an unlikely future knight and he almost wasn’t even a doctor. His parents thought he should be a Methodist minister, but he didn’t. He changed his course to medicine, graduated from the University of Toronto School of Medicine with four years of postgraduate training in ortho-

pedic surgery. During World War I he was cited for heroism and received the Military Cross.

After the war, in the summer of 1920, he set up what he had every reason to suppose would be a satisfying practice in London, Ontario.

But nothing happened. He went to his office every day, did all the right things, but there was—to put it conservatively—a minimum public response. At the end of one month, he had amassed a total of \$4. So when the University of Toronto opened in the fall he prudently decided to become a part-time demonstrator in the department of physiology and anatomy.

Charles Best, the 22-year-old son in a medical family from Maine, was a graduate student in physiology at the University in the spring of 1921. He had yet to receive a master’s degree.

A simple toss of a coin made him Banting’s partner in the medical spectacular that was to come. Another student—a Mr. Nobel, of all names—was supposed to work with Banting the last four scheduled weeks of the experiment. But Mr. Nobel never returned to take over.

What had spurred Banting to begin this intensive research was an

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article in the November 1920 issue of *Surgery, Gynecology and Obstetrics*. In the article, Moses Barron discussed the degenerative changes after the experimental ligation of the pancreatic duct or after the blocking of the duct by gallstones.

Banting wondered about the chance of a relationship between the islet cells of the pancreas and diabetes and extracting those cells by tying the pancreatic duct. He couldn't sleep.

He took his theories to J. J. R. Macleod, professor of physiology. Macleod, who three years later was to share the Nobel Prize with Banting, couldn't quite share Banting's enthusiasm in 1920. But since summer was approaching, he decided to let the young man have an unused laboratory, some 10 dogs left over from the regular school year classes and eight weeks to work while he went to Scotland.

Brought together by the coin toss, the two young men, whose talents and personalities were to mesh so fortuitously, went to work. It was May 17, 1921.

First they tied the pancreatic ducts of several dogs and performed

pancreatectomies on normal dogs to learn more about blood and urinary findings and how the animals reacted after the pancreatectomies. Seven weeks after the ligation of the ducts, they chloroformed two of those dogs and opened them up. They were surprised and upset to see that the pancreas had not degenerated and the ligature was still there. They had to start over—a second operation was necessary. This time, instead of one ligature, they applied two or more at different tensions along the duct. That procedure made the difference.

In July (the 17th according to Best, the 27th according to Banting), they had their first truly depancreatized dog and were ready to begin the important treatment.

According to Professor G. A. Wrenshall in *The Story of Insulin*; "To understand why it was a success, the notebooks must be studied carefully. When they had removed the degenerated pancreas, it was immediately put into chilled mortars and ground up with sand; this material was then suspended in Ringer's solution. All these operations were done in clean vessels as carefully as possible with the tempera-

ture as low as possible. This was an almost instinctive action on their part, and it was one, had they realized it, which made success possible, for the low temperature prevented any remaining protein-digesting enzyme of the main gland from inactivating the extract."

The treatment worked. The dog's blood sugar quickly went down, sugar eventually disappeared from the urine and the dog obviously felt better.

The two young men had indeed discovered insulin.

"By the nature of their experiment," says Wrenshall, "they felt that they had demonstrated conclusively that something from the islands of Langerhans was missing in diabetes, and in one leap they had secured some of this active principle, this mysterious 'X' substance, which could reverse the process of diabetes."

Perhaps one measure of the "ordinariness" of insulin today is that the word is rarely capitalized. It has become part of everyday vocabulary. But it wasn't always called insulin. Banting and Best referred to their substance as "isletin," after its origin in the islets of Langerhans. But, as Dr. Best reported in an interview last year, "Professor Macleod was rather insistent that the internal secretion of the pancreas was properly 'insulin.' Later on we found out that Sharpey and Schaeffer of Edinburgh had suggested 'insulin' about 1910."

The story of the insulin discovery would not be complete without mentioning Marjorie, or Dog No. 92. Banting, perhaps because of his farming boyhood, loved animals. He even trained some of the experimental dogs to raise their paws so blood could be drawn from their veins.

But Marjorie was extra-special: She was the first depancreatized animal kept alive by insulin. She lived



CHARLES H. BEST and Dr. Frederick G. Banting, photographed with Marjorie, the first depancreatized animal kept alive by insulin, at the University of Toronto, in 1921.



for more than 70 days on Banting's and Best's extract.

Marjorie, a two-tone setter-spaniel-type, also was the first to experience insulin hypoglycaemia, a condition that occurs when too much insulin lowers the blood sugar level below normal.

The notebooks tell the story: "It was decided to find out if an overdose of the extract would reduce the blood sugar of Dog 92 below 0.09% normal. Accordingly, at 11:40 a.m. blood was withdrawn. Blood sugar 0.11%, and 10 cc. of extract was given intravenously. At 12:30 p.m. the blood sugar equalled 0.06%. Blood became exceedingly dark on stirring with distilled water. At 1:00 p.m. the blood sugar was 0.076%."

They "did not allow themselves to become too excited." First they had to convince Professor Macleod of the validity of their discovery, so they kept on working and experimenting until he returned in September. Macleod wasn't impressed. He told them to repeat their basic experiments, without venturing further.

When they had 60 or 70 positive results, Banting and Best finally, on November 14th, 1921, presented their work to the medical faculty of the University of Toronto. They were impressed.

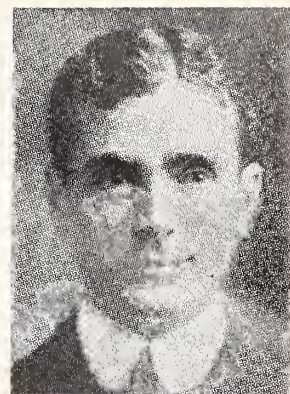
So were those who heard their presentation at the American Physiological Society meeting after Christmas at Yale. In the large audience was Dr. G. H. A. Clowes, director of research at Eli Lilly & Company in Indianapolis.

Such careful and cautious scientific presentations laid the groundwork for initial acceptance by the medical community but the excitement and anxiety of millions of diabetic sufferers could not be forgotten.

The scientists held off the clamor until January 11, 1922, when they started treating their first patients at the Toronto General Hospital. One

**DR. G. H. A. CLOWES, (far right)** research director of Eli Lilly and Company, at the time of his affiliation with the company in 1919.

**MR. GEORGE B. WALDEN,** chemist at the Eli Lilly Company, headed the team of scientists under Doctor Clowes.



Leonard Thompson, a severely diabetic 14-year-old boy, has the distinction of being the first patient to receive insulin. Leonard, whose diabetes was discovered when he was 11, weighed only 65 pounds. He was eating just 450 calories a day, had the "tell-tale" acidosis, enlarged abdomen, and was mostly bedridden.

Banting and Best prepared an extract from an adult beef pancreas, an abundantly available commodity (a necessity for future production), exactly as they had for all their previous experiments. They injected each other first but there was little reaction—just a small swelling and redness. Since they were not diabetics, there was no way of knowing for sure what would happen with Leonard.

His first treatment reduced the sugar in the blood and urine to normal but he did suffer skin reactions. Injections were discontinued until another "batch" of insulin had been produced. The "shots" were resumed. Leonard responded well—he stayed on his diet, added poundage and subsequently led a normal life. (In 1937, he died of pneumonia following serious injuries in a motorcycle accident.)

Other patients in Toronto joined the miracle of insulin. It had been a mere 20 weeks between the first injection of insulin to a diabetic dog and the first to a person.

In the meantime Banting was named to the university's department of pharmacology, and Best

had become a graduate fellow in the department of physiology. Their partnership was no longer a summertime thing but a necessary and desirable association of minds and goals.

By May 1922, insulin was being supplied in regular amounts from the Connought Laboratories where Dr. Best was director of insulin production.

By the next month the news had spread around the world—not just in scientific communities but, via the press, to millions of diabetes victims. The demand was overwhelming.

Also that spring, Eli Lilly & Company of Indianapolis, through research director Dr. G. H. A. Clowes, was interested in producing insulin.

He had been in that audience at Yale to hear Banting and Best but, according to Lilly records, he had known about their work since the previous summer: He learned of it through his acquaintanceship with Professor Macleod at the University.

There were many visits back and forth between Toronto and Indianapolis in the spring of '22 and the Toronto group agreed to collaborate with Lilly's for the large-scale production of insulin.

Within a year, Lilly's was producing a pure and potent form of insulin. Dr. Clowes' "lieutenants" were Mr. George Walden, J. P. Scott, Harley Rhodchamel and Lionel Chandler.



Lilly's began its clinical distribution of Iletin, as its insulin was and is called, in June 1922 and continued it to late January of 1923. There was no charge during that period but, with expenses accumulating, the company put certain clinical insulin on sale at cost, as provided in its agreement with the University of Toronto.

The August 1923 edition of *Tile and Till*, a Lilly publication, noted: "Early in November of 1922 a method was discovered in the Research Laboratories of Eli Lilly & Company whereby it was found possible to manufacture a pure, stable preparation of Iletin on a large scale, and after extensive experiments on animals the preparation in question was submitted to the investigating clinicians and was found to produce extremely satisfactory results when used in sufficient amount.

"The next obstacle was encountered in working out a satisfactory method of standardizing Iletin on account of the irregular results exhibited by rabbits and other test animals. By using very large numbers of animals on a statistical basis, however, and subsequently testing each lot in diabetic clinics, the standardization of Iletin is now fully equal to that commonly exhibited by biologicals which have to be standardized by means of animal tests."

The association of the Toronto group with Eli Lilly & Company was an excellent partnership. When, in October of 1934, dedication cere-

monies were held for new research laboratories at Lilly's, Sir Frederick Banting (he had been knighted in 1925) was on hand to recall the early days: "The Eli Lilly Company joined the Toronto group in their ideal of providing insulin to the greatest number of diabetics at the lowest possible price. It was largely through the untiring and well-directed efforts of Dr. Clowes and his associates that this ideal was fulfilled in such a short time."

The *Lilly Review* noted: "The answer to the need for purification, stabilizing, and an exact dosage and the demand for mass production was a highlight in the company's achievements."

Methodist Hospital in Indianapolis was one of the first institutions selected to receive insulin. Actually, the first American-made insulin (made by Lilly's) was administered to Miss Elizabeth Mudge at the New England Deaconess Hospital in Boston by Dr. Elliott P. Joslin's group on August 7, 1922. (When new research laboratories were dedicated at Lilly's in 1934, Dr. Joslin was there to report that Miss Mudge was alive and well, far from the 69-pound "severest of his severe" diabetic patients in 1922.)

Five days later, on August 12, 1922, Mrs. Nellie Underwood was given insulin from the same batch at Methodist Hospital.

(Heading the laboratories then at Methodist was Dr. John H. Warvel who reported that, although the Methodist Hospital staff was pre-

pared to administer the insulin in August, J. K. Lilly Sr., president of the pharmaceutical company, requested that Dr. Joslin, because of his prominence in the field, be allowed the honor of using it first in the United States. Dr. John A. MacDonald was the clinician on the Methodist staff.)

The young nurse who gave Mrs. Underwood her first insulin was Miss Ruth Michael. (Insulin was to have more than a professionally positive reaction for her: She married Dr. Warvel in September 1923.)

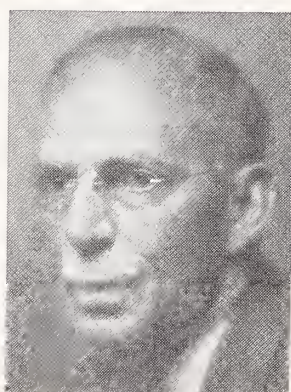
Miss Michael traveled to Chicago where, under the direction of Dr. Russell Woodyatt at Presbyterian Hospital, she learned how to weigh diets correctly and other "musts" in the new treatment of diabetics.

"Those were busy times," she recalls today. "We would give just one unit at a time, then take blood pressures every 15 minutes and collect specimens every hour. The diabetic patients weren't all in the same place either, and we did a lot of running around that hospital."

(Now, of course, diabetic patients at Methodist have their own unit, complete with its own special kitchen and a dining room for outpatients and diabetic patients, and not just those in the special unit, but any diabetic in the hospital. A new program at the hospital has an R.N. teaching classes to diabetics—how to weigh their food correctly and control their disease effectively.)

Mrs. Warvel especially remembers one early patient who came to couldn't have weighed more than Methodist from Michigan. "He 90 pounds when he arrived," she said recently at her home in northwest Indianapolis. "He reacted beautifully. He was a severe diabetic so he really had to weigh his diet very carefully: He had to become a 'religious' diabetic. He lived until 1947."

In a memorandum of September



DR. JOHN H. WARVEL, (far left) head of the Methodist Hospital laboratories in 1922. Photo taken in 1939.

DR. JOHN A. MacDONALD, Methodist Hospital clinician at the time of the first administration of insulin to a patient in Indiana.



14, 1966, Dr. Warvel noted: "Insulin in the beginning was given very cautiously. Later the dosage of insulin was increased in size and the insulin itself was made in much more potent suspension and dosages were brought up to as much as 22 and 60 units per day. . . .

"Early patients were taught the management of their disease, what it was, why it was important to control it. They were taught the symptoms of acidosis and how to recognize 'insulin shock'. . . .

"Many patients from all parts of the country wrote either to Lilly's or to the Methodist Hospital, wanting to come to Indianapolis for treatment." (Dr. Warvel, who resigned his Methodist post in 1925 to go into private practice, died in 1967.)

Thus the early story of insulin, a miraculous discovery that has saved and thereby changed the lives of millions. Before insulin, before those two young men went to work, the diabetic was a hopeless case, especially the young victim. The two young men reversed the hopelessness of almost 4,000 years and in 20 weeks provided hope and promise.

Whatever happened to them?

Best received his master of arts degree in physiology—with probably the most spectacular scientific credentials in history. He went on to get his M.D., then went to England to work with Sir Henry Dale.

In 1928 he received the doctor of science degree from University College, London. He returned to Toronto and the chair of applied physiology in the new School of Hygiene at the University. Professor Macleod returned to Scotland in 1929 and Best succeeded him to the chair of physiology at the School of Medicine.

Dr. Best still holds two posts, one at the Banting and Best Department of Medical Research, one as the

head of the Charles H. Best Institute. He was in Indianapolis last October to participate in a scientific symposium at Lilly's honoring the 50th anniversary of his epic discovery.

### Receives Nobel Prize

Dr. Banting received the Nobel prize for medicine (with Professor Macleod) in 1923. (Best has said his not being so honored was completely understandable. "I had only a bachelor's degree. I was not yet a physician and the Nobel Prize people don't give awards to undergraduates," he explained.) Banting however, did not forget his partner in the international limelight: He shared the monetary portion of the coveted prize with Best. He returned to private practice and joined the clinicians in the School of Medicine. Later, he worked on the etiology of cancer. As World War II approached, the discoverer of insulin became involved in other research projects. He was killed in a plane crash in 1941 while on a physiological research project for the Air Force. Sir Frederick Banting, the shy farm boy, was just 50 years old.

The immediate "proceeds" of their work have been the lives of millions—one estimate says 30 million people have been treated with insulin. But Banting's and Best's discovery also opened the door to still more questions that are still being studied today.

*Medical Tribune* Report recently asked prominent physicians and scientists to assess the value of Banting's and Best's discovery. Here is what they found:

"Insulin has led to more monumental advances in both clinical medicine and biochemistry than almost any other achievement," Dr. Charles R. Shuman, professor of medicine at Temple University, said.

"In the past half century alone we have witnessed such advances as the first analysis of a peptide molecule, development of a radioimmunoassay to measure as little as a microunit of insulin in plasma, the first synthesis of a peptide molecule—all made possible by the initial basic discovery of insulin."

"We must not forget," reported Dr. Rachmiel Levine, medical director of the City of Hope Hospital in Duarte, California, "that the primary significance of insulin lies in its human values. It has saved lives and prolonged life in severe diabetes. But its scientific significance has been immense and multiple: insulin opened the field of investigation of metabolic control by showing how a hormone regulates metabolism; it was the first hormone shown to be a protein and the first in which the principle of an immunoassay for a protein was achieved. It stimulated interest in the structural investigation of protein—all work of fundamental interest in biology and medicine."

Dr. Norbert Freinkel, Kettering professor of medicine and chief of endocrine clinics at Northwestern University: "In the first flush of enthusiasm, after the discovery of insulin, medicine thought it had solved the problem of diabetes. The anniversary should serve as a reminder of the essential humility that the biologist must retain in the face of enormous and unresolved enigmas of nature. Nature yields her secrets slowly and parsimoniously."

### ACKNOWLEDGEMENTS

THE JOURNAL gratefully acknowledges the help of Mr. Gene E. McCormick, corporate historian, Eli Lilly and Company, in obtaining the photographs used herein, with the exception of that of Doctor MacDonald, which was furnished by the Marion County Medical Society. ◀



Specific treatment, in the form of adequate dosage of immune serum gamma globulin, is recommended for infectious mono.

## *Review of Infectious Mononucleosis and Specific Treatment*

STANTON E. COPE, M.D.  
Huntington

**I**NFECTIONOUS mononucleosis has been known for approximately 80 years. Emil Pfeiffer described an epidemic in 1889 which fits the picture of this disease. The term infectious mononucleosis was first applied to the disease in 1920 by Sprunt and Evans. Their nomenclature was based on the fact that those affected showed an abnormal appearance of some of the lymphocytes in the blood smears.

Twelve years later, in 1932, Paul and Bunnell noted that the affected had an unusually high concentration of sheep cell agglutinins in the blood serum; thus the origin of the sheep cell agglutination test, which is known as the heterophile agglutination test for infectious mononucleosis.

### **Incidence and Distribution**

Infectious mononucleosis is world wide in distribution. It may occur at any age, but the greatest incidence is found in the late teens and early twenties. This fact was responsible for the impression that the disease was spread by kissing. This observation has not been substantiated.

### **Etiology**

All attempts to identify any etiological organism by culture, animal inoculation, or other means have

been unsuccessful. Recent electron microscope studies have given strong proof to the fact that there is a virus involved. Serological studies show that there is an antigen and antibody response in the serum of those affected. Thus, this disease, which is becoming more and more common, appears to have a viral etiology—e.g., the Epstein-Barr virus.

Some clinicians have recently emphasized psychosomatic aspects in the etiology of infectious mononucleosis. The facts on which they base their stand leave much to be explained.

Koch's postulates have not been fulfilled, but it would appear that they could be in the future. The antibody response gives incontestable proof to the fact that the disease is not psychosomatic, but of infectious origin.

### **Epidemiology**

Infectious mononucleosis may occur as an epidemic or it may appear in sporadic cases. The contagiousness of the disease appears to be of a low order since it is rare to see the disease in more than one member of a household at the same time. It is said to be slightly more prevalent in males.

The mode of transmission is not known, but it is thought to be airborne. Mouth to mouth transmission may play a part.

The incubation period is said to be 5 to 15 days, but this, too, is uncertain.

### **Signs and Symptoms**

1. Fever, sore throat and lymphadenopathy are nearly always present. Headache, stomatitis, mild to severe malaise and mild to extreme fatigue are often present.
2. Hepatitis, myocarditis and varying forms of neuritis and encephalitis occur in a small percentage of cases. Guillain-Barre's syndrome has been reported. Jaundice is not rare, nor is it common.
3. Splenomegaly is said to occur in 50% of cases and may be severe. Splenic rupture has been reported.
4. Skin rashes are neither rare nor common. The exanthemata vary, but are generally similar to those of syphilis, scarlatina or rubella. Whatever form the exanthema, it is transient.
5. In the subclinical case the major signs and symptoms can be so minimal that a diagnosis of infectious mononucleosis is easily overlooked.

### **Laboratory Findings**

1. Early granulocytopenia, fol-

lowed in about one week by a lymphocytic leucocytosis, is the rule. A percentage of the lymphocytes are abnormal in appearance. The abnormal cells are megalocytic and show vacuolization of both cytoplasm and the nucleus.

2. The heterophile test is usually positive, but may not become so until late in the disease—perhaps the third or fourth week or later. Thus, we have seen a few cases that clinically appeared to be infectious mononucleosis, but were not proved to be so by the agglutination test.
3. The mono spot test for this disease is also based on the detection of specific heterophile antibodies. This specialized test can be done in one minute.

#### Rare Laboratory Findings

1. Increase in cerebrospinal fluid pressure and elevated protein, as well as the presence of abnormal lymphocytes.
2. The EKG may be abnormal.
3. All liver function tests may be abnormal in the acute phase. Twenty per cent of those persons affected may show visible jaundice. Any laboratory test related to liver function, even the glucose tolerance test, may be aberrant.
4. Infectious mononucleosis may cause a positive VDRL.

#### Diagnosis

A positive diagnosis rests on the following:

1. A positive heterophile agglutination test.
2. Lymphocytosis with an increased percentage of abnormal lymphocytes.

#### Prognosis

Infectious mononucleosis is essentially a benign disease with very rare complications resulting in fatality or permanent sequelae. Death has resulted from splenic rupture and from asphyxia due to laryngeal swelling. Infectious mononucleosis has long been known to cause a long period of disability. Many athletes have been ineffective for weeks or months after a bout with the disease. Complete recovery with varying periods of morbidity and disability has been the expected course.

#### Treatment of Infectious Mononucleosis

Modern textbooks and current medical journals state that there is no specific treatment for this disease. It is our opinion from experience in treating over 60 cases that there is a very effective specific treatment. This treatment is nothing more than the use of an adequate dose of immune serum gamma globulin.

#### Suggested Treatment

1. Analgesics — This disease causes great morbidity. We feel that there is nothing better than codeine sulfate in maximum doses (up to gr. 1 q4h), ASA as needed for fever.
2. Antibiotics—It is our opinion that the judicious use of a broad spectrum antibiotic reduces morbidity by limiting secondary infections.
3. I.V. Fluids—This supportive therapy is rarely necessary but a few cases have been seen where inability to eat or take adequate liquids necessitates hospitalization for fluid and electrolyte therapy.
4. The use of steroids in severe cases has been recommended by most authors. Their value is questionable.

5. Immune Serum Gamma Globulin—It has been our experience that the giving of 10 cc of gamma globulin I.M. is dramatic in two to ten days in obliterating most of the debilitating symptoms of infectious mononucleosis. The injections may be given in the dosage of 2 cc daily for five days or 10 cc in one dose. The routine of 2 cc daily for five days merely gives the clinician a chance to observe the patient's daily response. The period of morbidity, in our experience, has been shortened by the giving of 10 cc at the first visit after a definite diagnosis has been made. The giving of 5 cc in each gluteus is advisable since it is less painful.

Younger patients are given a smaller dose of gamma globulin. According to age the dosage is reduced, but the disease is rarely seen in the age group less than adolescence, so the 10 cc dose is most often used. The dosage for the rare cases under 12 years of age should be judiciously decided by the clinician.

#### Case Reports

Case I. A 14-year-old white girl with the typical history of malaise, fatigue and a severe throat infection that had failed to respond to penicillin and tetracycline. Her heterophile test was positive: WBC 5,500 with 75% lymphocytes—25% reported atypical, heterophile agglutination was reported 1:448. She was given gamma globulin in the dosage of 2 cc per day for five days. I quote a letter from her mother, "Within one week of finishing the shots for mono, Mary was back to full activity. Exactly one week later she was camping and hiking in Brown County setting her own pace."



Case II. A young Purdue University student came home for Christmas vacation after three weeks of illness with infectious mononucleosis. Diagnosis was made at the Purdue Health Center. He appeared chronically ill and was jaundiced. He stated that he had had a weight loss of 25 pounds. He had no appetite and was exhausted. He had been on the accepted treatment of "rest and wait." He was given 2 cc of gamma globulin daily for five days after confirming the heterophile test. His recovery was dramatic. He returned to Purdue after vacation with no jaundice, a good appetite and feeling well.

Case III. A young school teacher returned home from her job in Bloomington to recover from infectious mononucleosis. The anterior cervical adenopathy was so marked that our office staff did not recognize her well known face. A positive diagnosis had been made in Bloomington. This young lady was given 5 cc of gamma globulin and advised to return in two days for evaluation. On examination two days later, it was observed that her anterior cervical adenopathy was al-

most gone and the pustular plaques on her tonsils had almost disappeared. She was given a second dose of 5 cc of gamma globulin and was able to return to her teaching duties in a few days.

### Summary

A review of infectious mononucleosis has been given with a specific treatment. Case reports were presented to show the effectiveness of this treatment. We have observed similar results in the management of more than 60 cases of infectious mononucleosis.

We feel that there is an effective specific treatment for infectious mononucleosis which in our experience has greatly reduced the morbidity and disability of this disease. The use of immune gamma globulin in adequate doses will be most rewarding to the affected patient and to the clinician.

"*Primum non nocere.*" Anaphylactic reactions have been reported after injection of immune gamma globulin. This risk exists with the use of any parenteral medication. For such a reaction we should *always be prepared and ready* to give

adrenalin, steroids and antihistamines.

"*Res ipsa loquitur.*"

"*No dude hasta que lo pruebe.*"

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### What's Needling You?

A 5,000-year-old Chinese medical practice is staging a phenomenal comeback in Europe, with skeptical modern doctors wondering if maybe the old sages didn't have something after all. Called acupuncture, the system assumes 12 body "meridians" carrying a flow of basic energy to the organs. If your toe hurts, the theory explains, it's because the energy flow has gone awry; to cure, stimulate the proper meridian with a silver needle. Surprising scientific find: The alleged meridian paths can now be traced (they have less resistance to electricity than other parts of the skin surface) and seem to correspond roughly with the autonomic nervous system. About 2,000 otherwise orthodox European doctors now practice acupuncture; France offers it on the national health service; Russians link it with Pavlovian conditioned-reflex principles. A few acupuncturists practice in the U. S., although the American Medical Association calls it a "counter-irritant of dubious value"—in the same category as mustard plaster and heat-inducing ointments. Reprinted from the May 21, 1962 issue of "The Insider's Newsletter." Copyright © 1962 by Cowles Magazines & Broadcasting, Inc.—JISMA, August 1962.

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# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen\***).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E\***).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

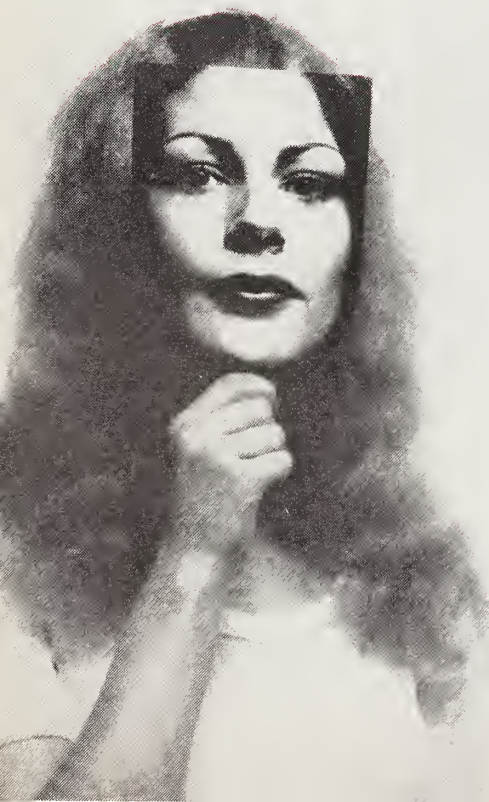
Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen\***).

Age 21, short, mammosome, with normal menses, some acne. Was put on pre-nuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E\*** or a sequential).





Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

\*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. Has recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E\*** or **Ovulen\*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen\***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen\***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen\***).

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Where "The Pill" Began

For a brief summary of prescribing information, please see next page.



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Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnanediol determination.

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**Indication**—Enovid-E is indicated for oral contraception.

The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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## Respiratory Distress Syndrome Treated with Exchange Transfusion

DONALD L. FIELDS, M.D.  
Kokomo

THE treatment of respiratory distress syndrome (RDS) is still unsatisfactory. The current treatment with monitored oxygen, correction of acidosis, circulatory support, temperature regulation, observation for secondary infection, parenteral feeding, respiratory assistance and other supportive care still allows a large number of deaths. Thirty percent of all infants who die in the neonatal period have a pathological diagnosis of hyaline membrane disease and 40 to 60 percent of those infants under 2500 gm show these changes.<sup>1</sup>

A new method of treatment shows great promise—continuous positive airway pressure using either mask or endotracheal tube. This has been far more successful than intermittent positive airway pressure. It apparently results in improved oxygenation due to increasing intra-alveolar pressure and by reducing atelectasis.<sup>2</sup>

Exchange transfusion has just recently been recognized to be beneficial in the treatment of RDS. One well recognized benefit is due to the increase of 2,3 diphosphoglycerate. (2,3 DPG) in *fresh* adult blood. This results in decreased oxygen affinity of the RBC with subsequently improved oxygen tissue release—a shift to the right of the

oxygen-dissociation curve. Ordinarily adult hemoglobin fails to bind 2, 3 DPG as does fetal hemoglobin. In infants with RDS a further shift to the left occurs than would occur in a normal infant of the same age. They show a marked decrease in 2,3 DPG.<sup>3, 4</sup> Fresh adult blood transfusion in the infant results in a prompt shift to the right allowing the infant to deliver more oxygen to the tissue at higher partial pressure of oxygen. Stored blood has depletion of 2,3 DPG and less shift to the right occurs.<sup>5</sup>

### Case Report

On July 13, 1969 at Howard Community Hospital, Kokomo, a two pound eleven ounce female infant was born to a para ii gravida iii mother who was group A-Rh negative. The indirect Coombs titre was rising and the amniocentesis curve was abnormal. Delivery was spontaneous and vaginal. Length of gestation was unknown. Her last infant weighed three pounds, had erythroblastosis fetalis and hyaline membrane disease. It died within 24 hours. No exchange transfusion had been done. The Hb had been 13 gms.

At birth the patient appeared small and immature. The color was good, but moderate retractions and

diminished breath sounds were present. There was no liver or spleen enlargement or edema. Chest x-ray was also compatible with RDS, showing diminished aeration and an air bronchogram. Cord blood direct Coombs was positive, blood group A-Rh positive, hemoglobin 9.0 gms, bilirubin 3.6 mg%.

Survival was not expected due to prematurity, RDS and moderate erythroblastosis fetalis. Exchange transfusion was done in the incubator using fresh compatible low titre O-neg blood. A two-volume exchange was done via the umbilical vein in 10 cc increments. Opening venous pressure was 7 cm blood. Calcium gluconate 10% 1.5 cc was given in divided doses during the procedure. She tolerated the exchange fairly well with at least no worsening of her condition clinically. Unexpectedly, two to three hours later the respiratory distress had disappeared—showing good aeration and no longer retracting. The remainder of her hospital course was uneventful.

Similar rapid improvement has been reported by Leonard Miller, M.D., at the University of Pennsylvania.<sup>3</sup>

Prevention of the development of RDS in premature infants by exchange transfusion has been studied.



In a study of 10 patients, all four exchanged infants lived, five of the six control infants died.<sup>6</sup>

Certainly, exchange transfusion should not be used for the treatment of all cases of RDS, but its use should be considered for the very ill infant who has not responded to the usual therapeutic measures.

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# Interactions Due to Drug Displacement

O. LeROY SALERNI, Ph.D.  
Indianapolis\*

AFTER a drug is absorbed, a portion of it remains in simple solution in plasma water and some becomes reversibly bound to the plasma proteins, particularly the albumin fraction. If, for example, only five in every one-thousand molecules of a drug remain free in solution in plasma water, it is this small number of unbound molecules which can combine with receptor sites to exert pharmacological activity.

When two drugs are administered which compete for the same albumin binding sites, displacement interactions can occur. Drug A, for example, is bound 99%. If Drug B is introduced and successfully competes with Drug A to an extent that only 95% of drug A remains bound, there is a fivefold increase in the plasma concentration of Drug A. Small percentage displacements may have profound effects when drugs are strongly bound, but small displacements for a drug which is not strongly bound (say, 50% bound) would be of little, if any, significance.

Basic drugs are weakly bound to plasma albumin and only acidic drugs are involved in important clinical interactions.

Drugs that have little displacing activity when used alone can

significantly interfere with the protein binding of another drug when present in combination. Probenecid (Benemid), sodium salicylate and tolbutamide (Orinase) individually showed little activity against sulfadimethoxine (Madribon) at 100 mg/ml, whereas in combination they produced a fivefold increase in the unbound fraction. Increasing the dose of a drug also may convert it from an inactive to an active displacing agent. Sodium salicylate at 100 mg/ml was inactive, whereas at 300 mg/ml it causes five times as much sulfadimethoxine to be unbound. An inactive drug may become an active displacing agent when plasma albumin is decreased. Sodium salicylate at 100 mg/ml was inactive in undiluted plasma, whereas it produced a fourfold increase in the unbound fraction of sulfadimethoxine in diluted plasma.

A number of acidic and highly bound drugs bis-hydroxycoumarin (Dicoumarol), ethyl bis-coumate (Tromexan), oxyphenbutazone (Tandearil), phenylbutazone (Butazolidin), salicylic acid and sulfapyrazone (Anturane) can displace albumin-bound sulfonamides and cause increased antibacterial activity.

The sulfonamides are capable of displacing several drugs from their binding sites. Tolbutamide (Orinase) is displaced and may produce hypoglycemia due to increased effect of tolbutamide on the pancreas. Bilirubin is released from albumin binding sites. In view of the large amounts of bilirubin present in

premature babies which may lead to the development of kernicterus, agents such as sulfonamide or salicylate that could displace bilirubin and thus precipitate or aggravate this situation are to be avoided. The apparent synergistic effect of penicillins and sulfonamides has been attributed to the displacement of penicillins from binding sites by the sulfas. Enhanced antimicrobial activity in serum was shown in the case of sulfas to be only partially reversible by p-aminobenzoic (PABA), suggesting that augmentation of penicillin activity was due to protein displacing effects as well as to the intrinsic antibacterial activity of sulfonamides. Sulfadiazine and sulfapyridine are two sulfonamides that are inactive as displacing agents of penicillins.

The demonstration that antibacterial activity of novobiocin and tetracyclines could not be augmented by the sulfonamides indicates that these antibiotics are bound to albumin at sites other than those that bind to penicillins.

Both the oral coumarin anticoagulants and phenylbutazone (Butazolidin) bind to plasma protein. The latter exerts a greater affinity for the binding sites, resulting in a displacement of the anticoagulant. Similarly, clofibrate (Atromid S), diphenylhydantoin (Dilantin), oxyphenbutazone (Tandearil), salicylates and indomethacin (Indocin) produce slight displacement of highly bound drugs such as bis-hydroxycoumarin to potentiate the anticoagulant effect and possibly produce hemorrhage due to over-

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inhibition of prothrombin synthesis in the liver.

Although diphenylhydantoin potentiates the effect of the coumarin anticoagulants, these anticoagulants produce a potentiation of the actions of diphenylhydantoin resulting in possible toxicity by retarding the enzymic degradation of the anticonvulsant in the liver.

Sulfonamides, salicylates, PABA,

barbiturates, tranquilizers and diphenylhydantoin can displace methotrexate. The cancer chemotherapeutic agent, of course, can cause serious toxicity and it is clear that increased quantities as a result of protein displacement can produce complications.

Binding to plasma protein may interfere with the desired action of

a drug by restricting it to the vascular compartment so that an insufficient amount of unbound, diffusible drug is available where needed. However, displacement of a drug from its bound state not only tends to increase drug action but also makes the drug available for urinary excretion via glomerular filtration and increases its rate of elimination from the body.

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—June 1972

Disease	Jun. 1972	May 1972	Apr. 1972	Jun. 1971	Jun. 1970
Animal Bites	1732	1277	859	1467	1313
Chickenpox	436	658	731	300	111
Conjunctivitis	260	254	168	171	142
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	38	22	82	28	25
Gonorrhea	1114	634	680	522	697
Impetigo	159	80	100	75	95
Infectious Hepatitis	50	53	41	39	46
Infectious Mononucleosis	73	126	131	53	56
Influenza	565	705	1164	351	321
Measles					
Rubeola	115	219	180	559	16
Rubella	68	103	83	520	117
Meningococcic Meningitis	1	1	0	1	1
Meningitis, Other	9	1	3	5	0
Mumps	82	126	153	510	191
Pertussis (Whooping Cough)	4	79	12	3	13
Pneumonia	382	357	306	257	275
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	903	1114	945	577	460
Syphilis					
Primary & Secondary	13	14	28	25	35
All Other Syphilis	157	85	71	87	150
Tinea Capitis	3	2	2	1	7
Tuberculosis (Active)	59	57	70	58	73

# The Cooper Quiz\*

## "Self-assessment"

JAMA, March 6, 1972

1. Osteoporosis is substantially in low fluoride areas.  
(a) more frequent  
(b) less frequent
2. There is a correlation between aortic calcification and osteoporosis. TRUE or FALSE
3. In a multiphasic screening examination of preschool children (Spanish - American community), chronic physical impairment was more common than emotional or mental impairment. TRUE or FALSE
4. Fetal heart rate monitoring does correlate with Apgar scoring. TRUE or FALSE
5. Catamenial pneumothorax is most probably related to endometriosis. TRUE or FALSE

JAMA, March 13, 1972

6. In the University of Washington study on the prognosis of ischemic heart disease, it was found that hospital fatalities were markedly influenced by patients' age rather than sex, race, marital status, hour of the

day and day of the week. Those below age 60 with myocardial infarcts fared better than those over 60. TRUE or FALSE

7. There are capillary changes in the capillaries of the conjunctiva in most cases of sickle cell disease. There is no relationship of the intensity of the conjunctival sign to the degree of sickle cell formation in an individual patient. TRUE or FALSE

....

9. Epidermic neuromyasthenia has no proven etiologic agent. TRUE or FALSE
10. Lithium carbonate in therapeutic doses (psychiatric practice) may produce anuria. TRUE or FALSE

JAMA, March 20, 1972

11. The cases of reticulum cell sarcoma in renal allotransplant recipients is times greater than in the general population.  
(a) 2 (d) 39  
(b) 6 (e) 81  
(c) 11 (f) 100

12. Lymphomas have developed in patients treated with azathioprine where no renal transplant was present. TRUE or FALSE

13. A pregnant addict, who is on methadone during confinement and delivery, may well have an

infant that needs to be treated for withdrawal. TRUE or FALSE

14. Addicts under 18 are the best candidates for methadone maintenance. TRUE or FALSE
15. Viral free water appears justified as a sound public health measure. TRUE or FALSE

JAMA, March 27, 1972

16. Maternal complications of women with sickle cell disease is well known. Pulmonary infarction is common. Pulmonary infarction is higher in (1) disease than (2) disease.  
(a) SC disease  
(b) SS disease
17. Gonococcal meningitis should be considered in patients with a past history of gonococcal infection. In such cases treatment should be delayed until urethral and/or vaginal culture are taken. TRUE or FALSE
18. Patients with cardiac decompensation may have liver scans that simulate cirrhosis. TRUE or FALSE
19. In a study of medical costs of patients on welfare "closed formulary" did not affect cost. TRUE or FALSE

Please turn to page 878 for answers.

\*We are indebted to Bill Snagg, M.D., Director of Medical Education, The Cooper Hospital, for permission to reproduce portions of "The Cooper Quiz." Published monthly by the Department of Medical Education, Cooper Hospital, Camden, N.J. 08103.



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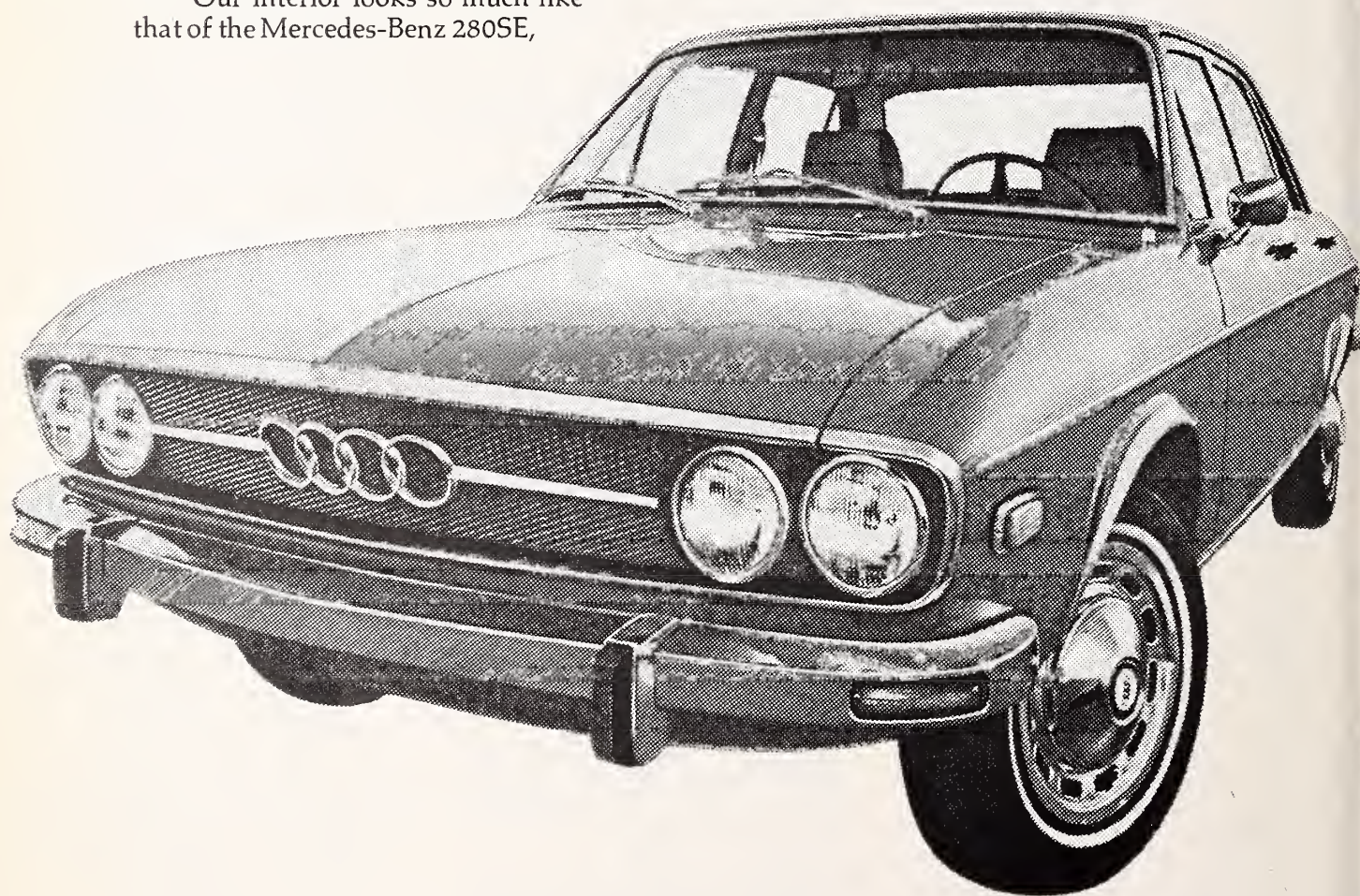
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## An Indiana Insulin Anniversary

INSULIN has celebrated a suc-  
cession of golden anniversaries dur-  
ing the past 12 months. In the short  
space of a year from July 1921  
to August 1922 the newly discov-  
ered wonder drug progressed from  
a laboratory curiosity to mass pro-  
duced commercial product which,  
even though still shrouded in mys-  
tery, was ready for clinical use.

This month will commemorate  
the 50th anniversary of the first  
clinical use of insulin in Indiana.  
On August 12, 1922, with elaborate  
precautions and safeguards, a clini-  
cal and laboratory group in the  
Methodist Hospital, Indianapolis,  
under the direction of Dr. John  
MacDonald, administered the drug  
to Mrs. Nellie Underwood.

Dr. John H. Warvel, Sr., was  
the chief pathologist at Methodist  
Hospital at that time. Miss Ruth  
Michael, later to become Mrs. War-  
vel, was the nurse assigned to this  
important team. Dr. C. L. Rudesill  
was associate clinical investigator.  
Dr. James Denny of Indianapolis  
was house officer at the Methodist  
for several years and recalls the  
meticulous clinical and laboratory  
work which characterized the clini-  
cal trial.

Originally insulin was adminis-  
tered in what would be considered  
today as small and even inadequate  
doses. Blood sugar determinations  
and observation of vital signs were  
conducted as often as every 15 or  
30 minutes.

Since methods of standardization  
were just being devised at this time,  
the strength of the insulin solution  
was best considered as slightly un-  
certain. The unitage of each lot  
was finally determined by observing  
its action in the patient.

But, despite the small doses and  
lack of previous experience and in  
spite of local tissue reactions due to  
slight impurities, the long dreamed  
of substance was validated. Patients  
who had been unmanageable by  
the then best dietary treatment be-  
came metabolically normal and,  
when they had learned how to ad-  
just their diets and received insulin,  
were able to live normal lives.

The Methodist Hospital record is  
even replete with the legendary  
example of the patient who "would  
not have lived if the medication had  
been discovered one day later."  
There is the young man who ar-  
rived from a neighboring state and  
was found to be severely acidotic  
and who survived impending coma  
to live another 25 years.

Such were the days of 1922.

Just a half a century has passed—  
a span which is relatively short in  
the history of mankind but one  
which has encompassed many phar-  
maceutical wonders, of which in-  
sulin is bound to be one of the most  
wonderful.

## Guest Editorials

### No Man an Island

THE isolation of insulin fifty  
years ago was instantly seen to be  
what posterity has affirmed—one of  
the great landmarks in the history of  
medicine. Sherrington, who was  
then president of the Royal Society,  
spoke of "the deserved success of  
a bold attack conducted with con-  
viction and determination, and car-  
ried through in the face of formid-  
able experimental difficulties."<sup>1</sup>  
Some quarter-century later Dale<sup>2</sup>  
recalled that in consequence of  
Banting and Best's achievement  
"from that point onwards the at-  
mosphere of therapeutic research on  
endocrine organs and functions be-  
came one of renewed optimism and  
enterprise." Of the chief players in  
this drama only Professor Charles  
Best survives, and happily he is  
taking part in the jubilee celebra-  
tions of the event beginning in  
Great Britain next week.



It is a truism that great scientific discoveries are not suddenly snatched out of the sky. Much work leads up to them, often the work of people who for one reason or another fail to share in the final achievement. And it is no disparagement of the Canadians' work to acknowledge that it too had its predecessors. Sherrington<sup>1</sup> himself drew attention to this in an apt quotation from Pasteur: "To have the fruit there must have been cultivation of the tree." Attempts to isolate a substance from the pancreas that would be a remedy for diabetes mellitus first occupied the attention of research workers in the first decade of the twentieth century. That story as well as its crowning conclusion has recently been the subject of a perceptive review by Professor Ian Murray,<sup>3</sup> timed to celebrate the centenary of Langerhans's description in 1869 of the islets that bear his name.

At some point before the first world war the distinguished Rumanian physiologist N. C. Paulesco began work on the isolation of the antidiabetic principle from the pancreas, but his research was tragically interrupted, Murray relates, when enemy troops occupied Bucharest in 1916. Thus it was not until 1921 that he was able to publish his results and so provide convincing proof of the hypoglycaemic properties in the dog of a pancreatic extract that he had obtained. Because Paulesco's work was completed—and by a narrow margin published<sup>4</sup>—before that of the Toronto team, medical circles in Rumania felt surprise and disappointment<sup>5</sup> at his not having any share in the Nobel prize that was awarded in 1923—but that award caused heartburning in other places as well. What had also occasioned some surprise,<sup>6</sup> as Professor E. Martin, of Geneva, has now noted, was the brief and mistaken impression of Paulesco's work given in the original

report by Banting and Best,<sup>6</sup> an impression wholly at variance with the generosity and goodwill of these authors.

Now an interesting footnote to history has appeared from Best's pen in the Swiss periodical *Schweizerische medizinische Wochenschrift*, for it is this odd discrepancy that Best has cleared up in a letter published by Professor Martin. In reply to an inquiry about this matter from Professor Pavel, of Bucharest, Best wrote as follows: "I regret very much that there was an error in our translation of Professor Paulesco's article. I cannot recollect after this length of time, exactly what happened. As it was almost fifty years ago I do not remember whether we relied on our own poor French or whether we had a translation made." Anyone who has tried to keep up-to-date in the world's literature on his subject will feel the keenest sympathy for Professor Best and acknowledge that such scrupulous amends are rarely made.

Banting was an inexperienced part-time demonstrator in physiology and Best a medical student when they achieved their great work with the assistance and in the laboratory of Professor J. J. R. Macleod at Toronto. Working at the same time in the department was J. B. Collip, a biochemist from Edmonton, on a Rockefeller fellowship, and it was he who succeeded in preparing sufficiently refined extracts of insulin for clinical use. The first patient, a boy of 12, was treated in January 1922, with encouraging results. Large scale manufacture of a pure preparation for the treatment of patients was now an obvious goal, and the Eli Lilly Company, brought in at the invitation of the Toronto team, turned its full research capacity on to the project. Patent rights were gifted to Toronto University and in Great Britain assigned to the Medical Research

Council.

How could any award to these resourceful pioneers, whose work had brought such inestimable benefit to humanity, be apportioned in a manner that justly acknowledged the drive, insight, and originality of each? In the upshot the Nobel prize was divided between Banting and Macleod. Dissatisfied with this judgement, Banting gave half his share of the prize to Best and Macleod then gave half his to Collip. But the team dissolved: "The clash of personalities of men working at an extreme pitch of exhaustion and the resulting split and break-up of this world-famous group must go down as one of the most unfortunate tragedies in the annals of medical research."<sup>7</sup>

Since those heroic days we have witnessed the determination of the structure of the insulin molecule by F. Sanger, who received a Nobel prize in 1958 for his work, and the elucidation of the crystalline structure by Dorothy Hodgkin, who had earlier, in 1964, won a Nobel prize for her crystallographic studies of large molecules. The biosynthesis of this hormone in the body is gradually being worked out and its mode of action elucidated. But to Banting and Best and their collaborators will always remain the honour of having enabled effective, life-saving treatment to be offered to millions of sufferers from a disease that for many of them was inevitably fatal.—*British Medical Journal*, 17 April 1971. Reprinted with permission.

<sup>1</sup> *British Medical Journal*, 1922, 2, 1139.

<sup>2</sup> Dale, Sir H. H., *British Medical Journal*, 1950, 1, 1.

<sup>3</sup> Murray, I., *Scottish Medical Journal*, 1969, 14, 286.

<sup>4</sup> Paulesco, N. C., *Archives Internationales de Physiologie*, 1921, 17, 85.

<sup>5</sup> Martin, E., *Schweizerische medizinische Wochenschrift*, 1971, 101, 164.

<sup>6</sup> Banting, F. G., and Best, C. H., *Journal of Laboratory and Clinical Medicine*, 1922, 7, 251.

<sup>7</sup> Noble, R. L., *Canadian Medical Association Journal*, 1965, 93, 1356.



## It Couldn't Happen Now!

**T**HE medical world is having numerous observances of the fiftieth anniversary of the discovery of insulin by Banting and Best. We should all be thankful that this miracle took place in 1921, because it probably couldn't happen now.

In the first place, neither Banting nor Best would qualify as researchers by today's sophisticated standards. Banting was an inquisitive surgeon with considerable orthopedic training and a faltering practice. Best was a meticulous postgraduate student of physiology and biochemistry. Neither had training in genetics, electron microscopy, statistics, molecular chemistry, computer data processing, or office management with emphasis on personnel relations. In fact, neither had a long bibliography of useless publications.

Any request from Banting and Best for research funds would have been passed over, not only because of their lack of superficial qualifications, but because in this brave new world of huge funding, they would not appear to be men of great vision. Who but a Banting or Best would borrow someone else's laboratory for a period of eight weeks and start his research with only 10 dogs? If they had submitted a 60-page grant request (in 20 copies) properly supported by bibliography, the resulting site inspection by their scientific peers would certainly have found that results from only 10 dogs could not be "statistically significant," and besides, the 10 dogs should have been selected at random and studied double blind as well. Anyway, no project of this scope could possibly be funded for less than \$250,000 annually for at least 10 years in order to determine the general direction of the project. It would then take a year or more to develop a suitable research team and obtain

necessary equipment. The grant would, of course, include a 40-50% overhead figure which should adequately take care of any administrative needs including payroll deductions, Social Security, state and federal taxes deducted from the employees, Blue Cross, Blue Shield, retirement funds, and other modern appurtenances to the "good" way of life.

The project would have been considered by the Research Committee at one of their quarterly meetings and eventually by the Committee on Human Studies. Of course, there were no human studies early in the research, but that is irrelevant. The Committee would meet in order to discover this fact for itself. Anyway, although humans were *not* involved, *dogs were*; and certainly the antivivisectionists and humane leagues should look into the prevailing conditions. Assuming all of these obstacles were surmounted and the Toronto Fire Department and Building Commission had found the laboratory safe and fireproof, the air conditioning functioning well (for the comfort of the animals), and all details worked out, Banting and Best still couldn't begin their research. For one thing, there is the matter of proper representation of various minority groups. This would demand the hiring of more people to effect a satisfactory ethnic balance, to say nothing of Women's Lib, as well as the demands of union regulations, all of which would have swollen the research team to a group much larger than the original two.

Most obvious of all, however, is the fact that both Banting and Best showed a deplorable lack of public relations sense and medical gamesmanship in announcing their discovery. In the first place, *before* the results were final, there should have been fortuitous "leaks" to both *Time* magazine and the *Wall Street Journal*. *Life* would have covered

their efforts with a four-page photographic spread entitled, "Life Goes to a Pancreatic-Duct Ligaturing." In a year or two, Best might have presented a paper at a medical meeting giving "preliminary, inconclusive results." These would be picked up by the extraneous quasi-medical periodicals. Some months later, the data would be presented to the appropriate national society, where it would be both endorsed and hotly disputed. Then a National Committee would be formed to consider the usefulness of insulin. Instead it would promulgate a final report entitled "Who Knows What Diabetes Is Anyway?" Banting would be interviewed by Hugh Hefner for *Playboy* magazine, where the host would equate lack of insulin with lack of sexual freedom, or vice versa.

Both men would have been the guests of David Susskind and would have appeared on the *Today* show. The *Christian Science Monitor* would cautiously quote a quote from a foreign correspondent. An untrustworthy lab assistant would steal the laboratory notes for publication in the *New York Times*; and *Pravda*, as always, would denounce the whole affair as a capitalistic plot. By now a paperback edition of the "true inside story of insulin" would have reached the newsstands and Hollywood would pay \$1,000,000 for the movie rights to "The Insulin Story." This would be made into a Hollywood opus with Raquel Welch taking the part of the diabetic dog and Richard Burton and George C. Scott cast as Banting and Best.

It is a pity that Banting and Best lacked the benefits of modern-day research and public relations techniques. However, it is just as well that the discovery of insulin happened as it did. With such primitive methods, so few experimental cases, such deplorable laboratory surroundings, and without the bles-



sings of the computer and the biostatistician, insulin would never have made it through the Food and Drug Administration anyway.

So it's a good thing the discovery of insulin happened 50 years ago, because it couldn't possibly happen now.—**Carl Bearse, M.D., Editor, Massachusetts Physician Nov. 1971, Reprinted with permission.**

## Is the Doctor Failing the Alcoholic?

When they talk about it, alcoholics and ex-alcoholics often charge physicians with being disinterested in treating them. And too often this is true. Alcoholics are not easy people to treat; you have to involve a whole family. They often don't tell the truth. They are not always conscientious at keeping their promises, sometimes they don't pay their bills, at times they get very nasty. Too often they seem to be badly motivated.

By a play on words, the concept of "illness" is translated as "something which is not my fault, which happens to befall me, and of which the doctor should cure me"—a description which might apply to pneumonia, but not to alcoholism. Alcoholism is an illness in the sense that it represents a physiologic inadaptability to handling alcohol, much as the diabetic has a physiologic inadaptability in handling sugar. However, we do hold the diabetic responsible for continuing to eat sweets after he learns of his metabolic disorder; yet we are asked to absolve the alcoholic from a similar kind of indiscretion on the grounds that this is his sickness. And perhaps the major deterrent to trying to treat the alcoholic is the doctor's usually poor batting average.

Yet, there are things that the physician *can* do. There is a place for disulfiram (Antabus®), and it calls for real pharmacologic judg-

ment in prescribing it. When the alcoholic is so tense that he needs another drink, there is a place for a tranquilizer, for the wisdom of changing the medication from time to time, and of avoiding making a pill-popper where the cure might be worse than the disease. There is a place for Alcoholics Anonymous, and the sophisticated doctor knows what that place is and how to use AA. There is a time to send the chronic alcoholic to a hospital, rest home, or sanitarium—a need for medical flexibility in selecting the appropriate placement. The family doctor must work with the family. If the patient is male, the doctor may have one of three attitudes toward the wife; sentimental, punitive, or psychological. The sentimental practitioner will pity the poor wife who has to put up with so much misery having an alcoholic husband. The punitive practitioner will suggest that she must have driven him to drink with her nagging, coldness, compulsiveness, or her rejection. The doctor who is interested in psychological subtleties will realize that most alcoholic males are immature and dependent and wonder what there was in the woman that made her select this kind of mate.

Sometimes it looks as if we were failing a patient—indeed a family—in trouble when the physician dismisses the alcoholic as too much to handle, too hard to treat. There are, after all, even worse diseases, more refractory ones, diseases with a higher relapse ratio. And that should not stop us from trying to help someone in trouble.—*The Journal of the Medical Society of New Jersey, June 1972. Reprinted with permission.*

## First Class Initial Care a First Consideration

ACEP is currently spearheading, or at least supporting, numerous di-

versified activities relating to the field of emergency medical care. These include attempts to gain AMA approval of an emergency physician residency training program, development of a nationwide categorization of emergency facilities and presentations of scientific assemblies and symposiums.

An important area of emergency health care which we as ACEP members should not overlook is the establishment of emergency councils on the local level. It is my opinion that we, as emergency physicians, have an obligation to participate as leaders in the formation of these councils. Once established, each council should give top priority to the design of first class initial care systems that will fill what may be the greatest gap in the emergency care of the sick and injured.

I am not talking about care delivered once the patient has reached the emergency department. Rather, I mean the care given a person before he reaches the ED.

To achieve the quality of primary care to which I am referring, we must somehow get to the victims faster and, once there, we must provide better care than we are now doing. To achieve the first point, it is necessary that we have improved communications, central mobile unit dispatch and choice location of emergency vehicles. Before the second point becomes a reality, we must have better equipped vehicles, emergency personnel trained to care for victims of all kinds of injuries and acute illnesses, two-way communications between emergency vehicles and the emergency department and monitoring and telemetering facilities.

This is where the big "push" should be—in the development of first class initial care. ACEP, with its knowledgeable, experienced members who are actively practicing this kind of medicine should wholeheartedly support, or even



better, lead the way to establishment of the local machinery which can implement the concept of better initial care.—**John H. van de Leuv, M.D., Editor, *Journal of the American College of Emergency Physicians*, Mar/Apr. 1972. Reprinted with permission.**

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## Editorial Notes

**The American Academy of Pediatrics warns against the use of filled milks, imitation milks and coffee whiteners instead of whole milk in infant diets.** Care is urged in use of these substitutes in older children's diets. Each of the substitutes, while satisfactory for the purpose for which devised, lacks some essential component that is desired in diets for infants and children. Filled milks are low in fats; imitation milks are inferior in protein, vitamin and mineral content; and coffee whiteners are low in protein, have a high sodium content, and lack other nutrients.

---

**A Saint Bernard dog has lived in the Saint Joseph's Hospital Research Laboratory in Saint Paul for a week with his heart partially assisted by an implanted, electrically driven artificial heart.** After removal of the device the animal was restored to normal and survived the test. No clotting occurred in the pump, and no damage to red cells was observed. The pump is three inches in diameter and five inches long. It weighs 2.2 pounds and operates on an external power source. During the experiment it assumed approximately 30% of the normal heart's load.

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**The Retail Pharmacist's Association and most of its members are in favor of retaining the present anti-substitution laws and regulations.** The pressure for repeal of the laws comes from elsewhere. Scharinghausen Pharmacy of Park Ridge

expresses itself in its *prn* Bulletin as follows: "We do not subscribe to the policy of using anything other than the brand specified by the physician. In an instance where we may not have the brand ordered you are well aware that we phone you to get your permission to use the brand in stock. Proponents of the action to repeal the law say that the Pharmacist has received more academic training in the area of drugs and pharmaceuticals and therefore is qualified to decide what brand to use. We may have received more training academically and over the years, experience may have helped us know what manufacturers have the best quality controls for their products. However we do not have access to the patient history card with a profile on diagnosis, treatment in the past, response to certain drugs . . . favorable or unfavorable. We believe that only the physician having all these facts before him is qualified to decide which drug and which brand is indicated. . . ."

---

**The Veterans Administration has found that pacemakers may be utilized to stimulate and regulate the breathing cycle.** Two radio receivers, each with an electrode around a phrenic nerve, are implanted in the body. One quadriplegic patient, who formerly lived in a mechanical respirator, now is able to be up and about and leaves the hospital regularly for entertainment and other reasons.

---

**The FDA has been criticized for its use of clinical investigators who have also performed studies sponsored by drug manufacturers.** The American College of Physicians answers that the FDA should consult with the most knowledgeable people available. Often the scientists who have conducted the clinical trials know more about a drug than any

one else and should be consulted regardless of the research support.

**The National Fire Protection Association warns about the fire hazards which are associated with the increased use of disposables in hospitals.** Since most hospitals were not designed with sufficient storage room for the large volume of disposable supplies necessary, it is urged that hospitals buy in smaller quantities and have storage areas protected by sprinkler systems and other fire prevention devices. The fact that the burning of some plastics creates toxic gases should be remembered.

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**There are an estimated 400,000 narcotic addicts in the United States, about half of them in New York City.** The Metropolitan Life Statistical Bulletin reports that narcotic-related deaths in New York City are sixfold what they were 10 years ago, with most of the increase since 1966. New York City estimates are that some 4271 persons died from narcotic abuse in "fun city" during the 1960s, compared with 1076 such deaths during the 1950s.

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**The Pharmaceutical Manufacturers Association opposes the move to repeal state ant substitution laws as related to the filling of prescriptions.** Recent events which demonstrate the fallacy of therapeutic equivalence are cited as one of the PMA's reasons for the stand. The Association points out that the main reason for the move to repeal ant substitution laws is a desire to lower prescription costs—a result that probably would not be achieved. Most pharmacists, when uninstructed as to the brand, tend to dispense products of recognized dependability and charge the same price as they would for other products. Unethical pharmacists, when presented with a choice, might dispense the most expensive brand. ◀



# A Guide to Teaching as a Preceptor

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Indianapolis\*\*

## Introduction

"*U*OW do I work out what I'll teach?" This fundamental question quickly comes to mind when the physician decides to become involved in the Preceptorship Program, and no doubt is the basis for a good deal of apprehension amounting to, in some instances, perhaps fear. Equally important, the physician asks "How will I be sure that I'll come across with what I've decided to teach?" Eventually, the school sends an evaluation form to grade the student and you'll want to know. "How do I know he has *got-ten* what I've *given*?" These and other issues encompass the teaching task and illustrate the need of preparing a comprehensive guide for teaching as a physician. Not only are these questions vital guidelines in teaching effectively as a physician, but the *order* in which they are considered is important. Obviously, the first question must be answered prior to the other two.

The primary purpose of this paper is "how to" prepare for the job of teaching students in family medicine. With the all-important clinical responsibilities constantly at hand, it is perhaps natural for the physician to feel that it is neither possible nor necessary for him to specify his

teaching responsibilities. On the other hand, it is assumed that physicians are interested in communicating certain skills, knowledge and attitudes in such a manner that the students will be able to *demonstrate* their achievement. Consequently, it behooves physicians to consider the means to this worthwhile end. We consider this as a suitable framework for meeting the teaching requirements in the Preceptorship Program. The ultimate value of this guide will depend upon the degree to which physicians are motivated and directed to communicate their own instructional goals.

## The Teaching Process

Basically, four sequential steps are involved in successfully teaching as a physician. These may be outlined as follows:

1. The physician must first *identify* what it is he needs to teach. These should be referred to as the instructional objectives of your program. They may not be congruent with what he wants to or does not want to teach. Generally, the discipline (i.e., Family Medicine) decides this and represents the physician's blueprint, clearly stating the teaching destination.
2. The physician must *select* or prepare concepts that are germane to these instructional objectives. A concept is considered as a complete and meaningful idea(s) you want to get across to your students and represents the major unit(s) to be taught. This

step specifies the most efficient route to your destination.

3. The physician must cause the students to *interact* with these concepts in accordance with the *well established principles of motivation*. This step is the catalyst and keeps the physician on track.
4. The physician must *evaluate* the student's terminal achievement according to the instructional objectives stated in Step One. This last step unequivocally tells both the physician and the student whether or not they have reached their destination.

These four steps are the required kinds of activity that are necessary if the physician is to succeed as a teacher.

## Developing Teaching Objectives

To begin with, a careful specification of teaching objectives is essential in the teaching program. Simply stated, an objective is the description of a *product*, that is, what the student is supposed to demonstrate as a result of the teaching *process*. The statement of teaching objectives must specify *measurable* characteristics or outcomes observable in the students. These teaching objectives represent a clear picture of your instructional intent, which is a description of a pattern of behavior you want the student to be able to adequately demonstrate when he has successfully completed the Preceptorship. When a student can do this, you can safely assume that you are measuring his performance in terms of objectives. Be-

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ing able to adequately develop teaching objectives has several important advantages as cited below:

1. **Organization**—It presents a means of organizing your teaching efforts into relevant activities. It no doubt makes it easier to select the experiences you consider worthwhile in meeting the objective.

2. **Behavior**—It enables you to measure demonstrable terminal behavior at the end of the Preceptorship and helps to determine how efficient your teaching program is.

3. **Justification**—It permits validation and support for the Preceptorship program, both within and outside of the discipline. This will assist in providing visibility in the local community.

4. **"Edutainment"**—It supports theory that teaching-learning can be enjoyable for the student, as well as the physician.

5. **Conceptualization**—It provides assistance in the development of concepts, which are the operational units of teaching.

6. **Testing**—The specification of examination questions is simplified since you have determined the structure of your program.

7. **Instructionalization**—The formulation of instructional strategies and methods is enhanced and suggests what materials will function most efficiently in teaching what we wish to teach.

8. **Visualization**—It enhances meaningful pictorial representations of program elements. Reliable research shows that as much as three-fourths of learning takes place through the visual medium. This observation should be capitalized on.

9. **Evaluation**—Your ability to objectively and reliably evaluate the overall success of the Preceptorship Program is facilitated.

On the other hand, there are some disadvantages of not correctly preparing teaching objectives. Perhaps the biggest problem is the

likelihood that misinterpretations will occur since certain words used in framing objectives are open to many interpretations (e.g., "know," "understand"). As a result, poorly stated objectives neither define nor preclude any behavior, making it possible, if not more likely, that almost any type of performance will be accepted as evidence that the student has succeeded. In addition, with poorly stated objectives, the student is not encouraged to organize and direct his own efforts or activities in order to achieve them. In other words, the student is unable to use effectively the statement of teaching objectives as a means of gauging his own progress. We must, therefore, know how to prepare teaching objectives.

### The "How To" Procedure

In order to write teaching objectives that will conform to the model, two guidelines are provided as follows:

**GUIDELINE #1**—Clearly specify the kind of performance that will be accepted as *prima facie* evidence that the student has achieved the teaching objective. Such behavior is referred to as "terminal behavior" and may be either verbal or non-verbal and is perceived for each skill that you want the student to acquire.

**GUIDELINE #2**—Identify the criteria of acceptable performance. This includes a description of the requirements or conditions under which the student must function.

Basically, the "how to" procedure normally includes writing statements that describe your educational intent in behavioral terms and then modifying or expanding them over time to make them more meaningful, explanatory and clear to both the physician and the student. The teaching objectives for your entire program should probably consist of several pages of useful specific statements. Experience has shown

that there are two basic ways for measuring the sharpness or degree to which a single objective is clear and meaningful. These two ways can be illustrated below:

1. First, compare your written stated objective with a set of selected test items, prepared by the physician. On the basis of this comparison you simply accept or reject each test item, depending on whether or not the objective included the behavior asked for. If it is necessary to accept all types of test items as appropriate, the objective needs to be more specific. If the objective permits you to reject those items not appropriate, we can conclude that the objective then meets the criterion of clarity. This technic can be briefly shown with the following self graded example.

*Hypothetically Stated Objective.*

"Provided with a properly functioning electrocardiogram of any model, the student must be able to make the adjustments and control settings essential prior to conducting a standard electrocardiogram." *Check* which of the following test situations would be appropriate or acceptable for deriving the kind of behavior by which we could tell if the student had reached the hypothetical objective as stated above. The assumption is that this objective is well stated.

- \_\_\_\_ 1. List the steps, in their proper order, for setting up an electrocardiogram.
- \_\_\_\_ 2. Describe the steps followed in the conduct of a standard electrocardiogram.
- \_\_\_\_ 3. Discuss the role of the electrocardiogram in family medicine.
- \_\_\_\_ 4. Proceed to an electrocardiogram and set it up so that it can be used to administer a standard electrocardiogram.



For obvious reasons, number four is the only one relevant to the stated objective.

2. Second, apply the same procedure to a poorly stated objective. Then on the basis of this comparison you look to see if any test items could be considered unacceptable or inappropriate for determining whether a student has reached your stated objective. If the test items cannot be considered inappropriate, the stated program objective is unclear and hence inadequate. In such an instance, you really do not specify what it is you want your student to learn. This technique can also be briefly shown with another self graded example.

*Hypothetically Stated Objective.*

"The student must be able to understand the significance of the State's Public Health Laws." Check which of the following test situations would have to be considered appropriate for testing whether the objective has been achieved. The assumption is that this objective is poorly stated.

- \_\_\_\_\_1. The student is asked to recount the title of each of the State's Public Health laws.
- \_\_\_\_\_2. Given copies of the state's various Public Health laws, the student is asked to identify those which apply directly to Family Medicine.
- \_\_\_\_\_3. The student is asked to answer 100 multiple choice questions on the subject of Public Health laws.
- \_\_\_\_\_4. Given selected copies of various Public Health laws, the student is asked to interpret their application in specific problematic situations (i.e., epidemic).

Choices numbered two, three,

and four can be considered acceptable, appropriate, fair and relevant to the objective as it is stated above, since the objective did not tell us what we were to look for when the student was demonstrating that he understood the significance of the State's Public Health laws. In other words, the objective as it is stated includes too many possible valid test situations and really does not communicate your intent to the student. Furthermore, it precipitates frustration and anxiety, an unholy alliance in teaching. We can readily see how important it is to know "How To." A companion concern is the attention given to the achievement level expected by the physician. This signifies the level of quality reflected in the program.

**Quality Control—  
The Success Criterion**

The performance standard against which you can measure the success of your teaching endeavor as a physician is called the "success criterion." Not only do we want to be able to tell the student "what it is we want them to be able to do" but also "*how well* we want them to be able to do it." This final aim is achieved by describing what is referred to as the "intended criterion of minimal acceptable performance." Following is a list of the most common ways in which the criterion of minimal acceptable performance can be specified or put into words in the statement of objectives.

1. *Time Limit.* Specify that the objective must be accomplished within a specified amount of time. This permits you to organize your teaching into realistic time blocks. What activities are intended to be time related and what skills must be acquired before the student proceeds?

2. *Quantity Limit.* Formally or otherwise, specify the minimum acceptable skill. Generally, this can be done by describing the lower limit of acceptable performance. Ordinarily, this is best achieved by indicating the number, percentage or proportion of correct responses considered equal to acceptable performance. Applied to Family Medicine, it might, for example be designated in terms of patient load.

3. *Quality Limit.* Define in more detail the quality of acceptable performance. We can show how this is done with a behavioral science objective as given below:

*Hypothetical Behavioral Science Objective.* "The student is to prepare and analyze a case presentation each week." Further defining the important characteristics of performance accuracy might include the following:

- a. This case presentation is to be developed according to the format derived during the First Annual Preceptorship Seminar.
- b. The student must demonstrate having considered the case presentation from at least two additional points of view (i.e., nurse, psychiatrist).
- c. Outside sources may be utilized.
- d. Up to one week may be taken in preparing the case.

4. *Deviation Limit.* This can be done by depicting the amount of acceptable deviation from the given standard in your practice and/or experience. For example, if certain calculations were being used this could be achieved by specifying that figures be accurate to at least two or three significant figures. These limits could be applied to patient records and chart values.

In each of the above instances, we set out to prescribe limits within which the student is expected to perform if he is to succeed in the teaching program. Knowing these limits perhaps represents the greatest single need of students, and

ironically, not prescribing such limits represents the greatest fault of the teaching program. Although the foregoing is essential, it is stressed that each physician must prepare or tailor teaching objectives suited to his own situation.

### Summary

The purpose of this presentation has been to develop a framework for preparing objectives in the phy-

sician's teaching program.\* It is agreed that one should be able to evaluate functions and behavior that we judge to be important enough to spend varying but significant amounts of time teaching. Using this framework will help to test both the clarity and efficiency of our objectives. It will also provide us with a sound basis for selecting

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\*While specifically intended for Preceptorship training, this guide can well be used by Family Practice Residency Programs.

the types of learning experiences to be included in the Preceptorship Program. In most cases, the specific objectives you construct will require more than one sentence to achieve or communicate their intent. This is particularly true when you are preparing objectives involving synthesis behavior, like Family Medicine. Once provided with teaching objectives that communicate the intent of the physician, he may have little else to do. Begin now and aspire to communicate! ◀

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## From THE JOURNAL 50 Years Ago

A very interesting phenomenon in the use of local anesthesia in the performance of major surgery is the very profound effect upon the psychology of the surgeon. The mental reactions of the local anesthetic patient have been discussed at some length. Of no less significance is the striking change in the mental process of the surgeon, when in the one instance he is operating on an unconscious patient and the other a fully conscious and intellectually alert individual. He immediately becomes aware that he is operating on a living, conscious, human being whose physiological processes are intact and the tissues of whose body react in direct ratio to the injury done them. Blood vessels, nerves, fasciæ and muscles all have a new significance.

When we stop to reflect on the early training of surgeons, it is not difficult to understand how we may develop with an improper attitude toward living tissue.

The student's first introduction to the manual exploration of human tissue is in the dissecting room. It is unnecessary to remark that here delicacy of touch is not regarded as an essential quality of good technique. The next step in his training is a course in operative technique on the cadaver and later a course in dog surgery. By the time these courses have been completed, whatever instinctive reverence the student may have possessed for living, human cells has disappeared. He begins operating as an assistant on unconscious patients whose tissues become the recipient of the same kind of manipulation as used in the dissecting room or dog surgery.

I have repeatedly observed internes, while assisting them in hernia and other operative procedures, show a disregard for the rules of gentle manipulation that I feel sure was an acquired and not a natural trait. With an alert human being under the knife, the tissues involved take on something of the significance of conscious existence and it would, in my judgment, add greatly to the value of surgical training if the student did his first operative work under local anesthesia. . . . M. N. Hadley, M.D., Indianapolis, "Local Anesthesia as a Supplement to General Narcosis," JISMA, August 1922.



# ART, HOBBY SHOW PLANNED FOR ISMA ANNUAL MEETING

Space will be provided at the 1972 annual meeting of the Indiana State Medical Association, October 16, 17 and 18 at Indianapolis, for an Art and Hobby Show.

Members of the ISMA and their wives are invited to participate. Information regarding this year's show may be obtained from:

Indiana State Medical Association	or	Mrs. Harry Siderys
3935 North Meridian Street		9015 Kirkham Court
Indianapolis, Indiana 46202		Indianapolis, Indiana 46260

It will be the responsibility of each exhibitor to see that his work gets to and from the new Indiana Convention-Exposition Center, 100 S. Capitol Avenue, Indianapolis. (The final arrangements will be provided by the committee.)

ISMA will provide suitable display facilities, but each exhibitor is responsible for transportation costs or any other such expenses involved in entering his exhibit.

In order that the committee may do its best in fulfilling the needs of your exhibit, it is ESSENTIAL that you accurately indicate below the amount of space required for your exhibit.

ALL exhibits must be labeled with your name and address and each should be titled.

We do not encourage rare or valuable exhibits since their safety cannot be insured.

In order that the committee may be adequately prepared for your exhibit, ALL applications must be submitted no later than OCTOBER 8, 1972.

We solicit your exhibit to make this year's show the most successful.

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## APPLICATION for SPACE in ART and HOBBY SHOW

Exhibitor \_\_\_\_\_ Total number items to be exhibited \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_

CATEGORY*	TITLE	SIZE or SPACE REQUIRED
_____	_____	_____
_____	_____	_____
_____	_____	_____

We also need several people to accompany the exhibit for short periods of time during the convention; if you can help, please indicate below, and a member of the committee will contact you to arrange a convenient time period for you.

YES \_\_\_\_\_ NO \_\_\_\_\_


MAIL TO:

Mrs. Harry Siderys  
9015 Kirkham Court  
Indianapolis, Indiana 46260

DEADLINE for submission  
of application is:  
OCTOBER 8, 1972

\*Please indicate whether your exhibit is oil, watercolor, photography, sculpture, or arts and crafts, etc.





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- low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

**Vanishing Cream Base**  
**Neosporin<sup>®</sup>-G Cream**  
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.  
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

**Precaution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



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## When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

### **1.2 to 8 grams/day IV dosage range:**

Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections.

In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

### **Effective gram-positive antibiotic:**

Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone





infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

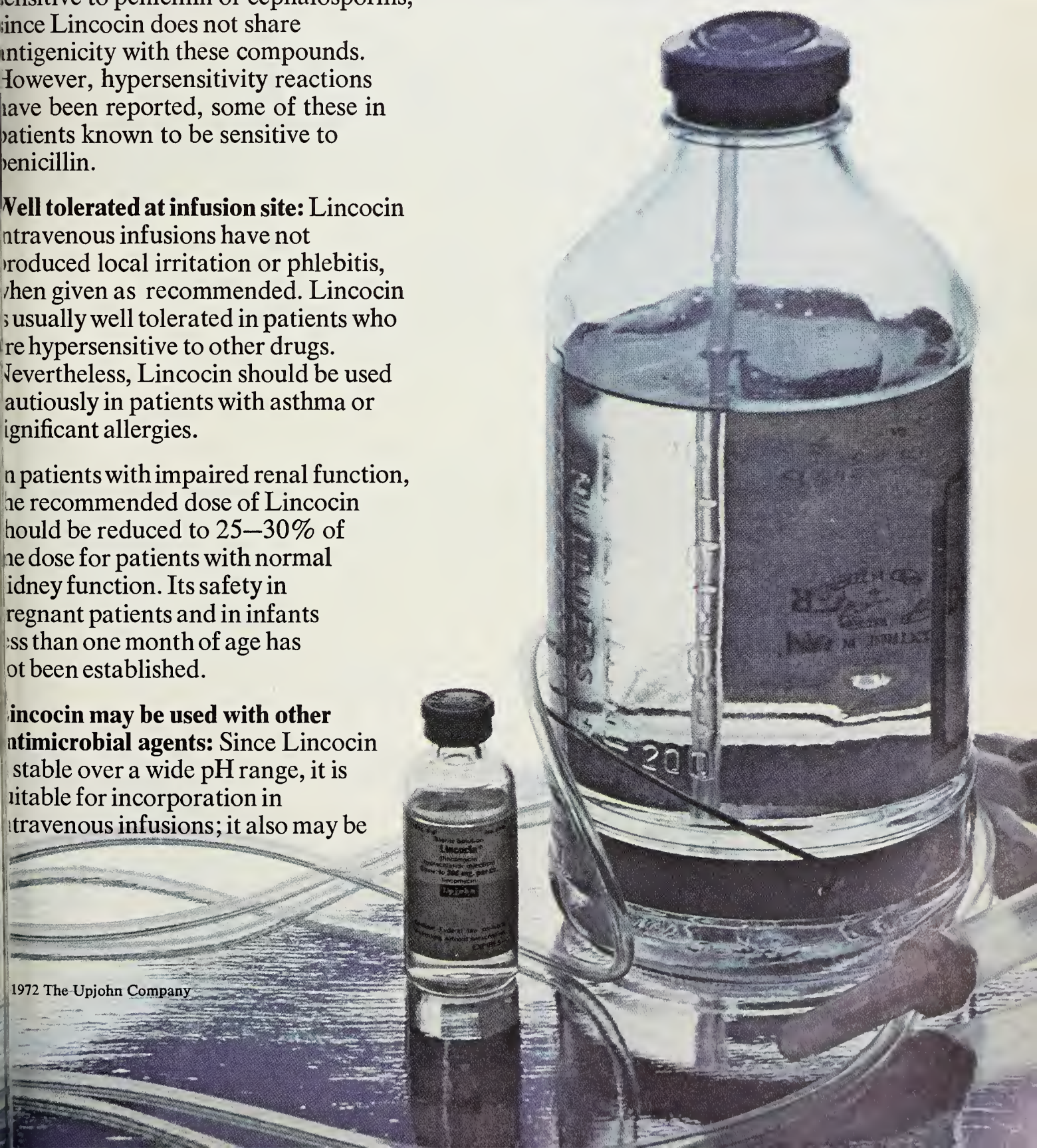
**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

**Lincocin<sup>®</sup>**  
Sterile Solution (300 mg per ml)  
(lincomycin hydrochloride, Upjohn)  
For further prescribing information, please see following page.







Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

## (lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections.

Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:

Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg Pediatric Capsule ..... 250 mg  
500 mg Capsule ..... 500 mg  
\*Sterile Solution per 1 ml ..... 300 mg  
Syrup per 5 ml ..... 250 mg

\*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonomial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rash, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reaction*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg and 500 mg Capsules—bottles of 24 and 100. *Sterile Solution*, 300 mg per ml—2 and 10 ml vial and 2 ml syringe. *Syrup*, 250 mg per 5 ml—60 ml and pint bottles.

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# A New Medical Practice Act for Indiana

MERRITT O. ALCORN, M.D.  
Madison\*

ATTEMPTS are made in almost every legislative session to amend the Medical Practice Act. Many of these efforts come from pressure groups with good intentions but with little knowledge of the problems, and with no understanding of the fact that passing laws is usually a poor remedy for most needs. The Indiana State Medical Association's staff should be commended for its fine efforts in preventing passage of ill-conceived legislation that would damage the standards of the practice of medicine in Indiana.

The medical profession in Indiana has had a growing awareness that our 75-year old Medical Practice Act is inadequate to discipline those who abuse the privilege of the practice of medicine and who may be harmful to the public. There has been a mandate by the State Medical Association that the disciplinary portion of the act be strengthened.

The constantly changing patterns of medical education and practice often come in conflict with the rather rigid laws patterned for the practice of medicine in the latter part of the nineteenth century. A new law is needed to cope with the increasing responsibilities of registered nurses and physicians' assistants.

A new act is being carefully considered by the medical and osteopathy professions of the state with review by many health agencies, the hospital association, and administration of the medical school. Sufficient

time is being given to allow for deliberation on the many aspects of the bill so that in its final form it will represent the consensus of informed physicians and have broad legislative support.

The base for discussions of the new practice act has been the guide for a uniform practice act that was prepared by a committee of the Federation of State Licensing Boards. There are efforts by all the states to bring the laws and the construction of the Licensing Board to as uniform a position as possible to facilitate endorsement and co-operation between boards.

## Definition of Medical Practice

It is important to have a concise definition of the practice of medicine because ultimately every disagreement concerning what constitutes the practice of medicine is solved by an interpretation of the definition as given in the Medical Practice Act. Under definitions are placed the exceptions—such as students in training, individuals rendering emergency care, physicians in the armed forces, or physicians residing in another state who are called in consultations. These exceptions prevent unreasonable prosecution.

There are also exclusions for those licensed to practice in a limited field, for professional or domestic nursing, for nurse anesthetist, and for physicians' assistants. These exclusions allow individuals who have been highly trained in an area for the practice of medicine to perform so long as they have met

an accepted level of training and work properly with the total medical care team.

## Physicians' Assistants

There has been so much diversity of thought over the use of physicians' assistants that it is important that we not try to create this entity by legislation but do allow for physicians' assistants to practice at such a time as they have become recognized, have a standardized training curriculum, and have a certification program. Another concern would be that the physicians use assistants in a manner acceptable to the profession.

The new act could deal with this exclusion specifically by stating that the use of physicians' assistants would not be affected or prevented, provided the assistant was certified by a registry approved by the Licensing Board or was graduated from an institution approved by the board for training physicians' assistants. The other provision would be that physicians or institutions employing physicians' assistants would be registered by the Licensing Board for such employment. This type of approval should best be done by the Medical Society; however, it would have to be placed under the Board to have any legal status. It would be necessary for the Board of Registration to work directly with the medical and osteopathy societies in controlling the proper use of medical assistants.

## Licensure Requirements

It is recommended that the re-

\*President, Indiana State Board of Medical Registration and Examination.



quirements for obtaining an unlimited license to practice in the state of Indiana be as uniform with the other states of the union as is possible. This would be true for both graduates of American medical schools and schools of osteopathy and graduates of foreign medical schools. The provision requiring that the graduate of a foreign medical school have two years of post-graduate education prior to taking a licensing examination is an excellent requirement, in that it provides an opportunity for the applicant to understand the system of practice, methods of referrals and consultations, and the drugs used in this country. It also gives a licensing board an opportunity to obtain a recommendation from an American institution on the individual applicant as to his use of the English language and standard of medical ethics.

#### **Grounds for Probation, Suspension, and Revocation of Licenses**

The present Medical Practice Act does not have provisions for probation or suspension of the license. It is important to have these lesser degrees of punishment, particularly since the grounds on which charges can be brought against the physician are being considerably expanded. A physician cited to come before the Board for violation of a section of the disciplinary portion of the Act is not necessarily punished, even if found guilty of the charge. A good example of this would be a physician charged with having committed a felony. It is important that anyone committing a crime of the degree of a felony be reviewed; however, there are many circumstances in which such a crime would not prevent the physician from being capable of practicing good medicine and no disciplinary action would be indicated.

The principal difference between the charges in the new act and

those in the previous act are that we are now recommending the control of medical ethics. This has always been the domain of the medical societies; however, organized medicine has become concerned that those who are unethical in their practice and need disciplinary action are usually outside of the medical society and that those who are within the societies are disciplined by putting them outside of the society's control. There can be no effective disciplinary action for the unethical practice of medicine unless it is included in the Medical Practice Act.

Changes recommended for the new act that were not specifically present in the former Medical Practice Act are:

- A. Becoming addicted to a drug or intoxicant to such a degree as to render the licensee unsafe or unfit to practice medicine and surgery.
- B. Insanity or mental disease.
- C. The selling of dangerous drugs to a habitue or addict.
- D. The performance of any dishonorable, unethical or unprofessional conduct likely to deceive, defraud or harm the public.
- E. Gross carelessness or manifest incapacity in the practice of medicine or surgery.
- F. The advertising for the practice of medicine in any unethical or unprofessional manner.
- G. Obtaining a fee on fraudulent representation that a manifest incurable condition can be permanently cured.
- H. The willful violation of privileged communication.

Most of the control of the violations of these charges would be held by the local community of physicians because they are the ones who are usually responsible for re-

porting offenders to the Board and for providing the testimony for conviction. For instance, a physician charged with gross carelessness or manifest incapacity would not be cited if he were able to obtain recommendations from other physicians in the community, if he were on a hospital staff or an active member in good standing of a local medical society. He would not be charged by the Board unless there was general agreement by the local community of physicians.

#### **Injunction Clause**

At the present time it requires from three to six months to go through the procedures necessary for citation and revocation of a license. This is often an unfortunate delay if a physician is an addict, an uncontrollable alcoholic or is in a mental or emotional state that might harm the public. Although by principle we should consider a man innocent until he is found guilty, there are occasionally such situations in which the defendant is dangerous to the public and there should be some mechanism for preventing the practice of medicine while he is awaiting trial. The individual rights of the physician should be protected by requiring the Licensing Board to obtain an injunction from the Circuit Court before being allowed to suspend a license prior to the hearing.

The principles for a new Medical Practice Act recommended by the Federation of State Licensing Boards have been discussed in four area meetings over the state and, from the comments and criticisms received, the Indiana State Medical Association will draw the proper law for Indiana. Comments are invited and should be directed to the Chairman of the Commission on Education and Licensure, Indiana State Medical Association, Franklin A. Bryan, M.D., 700 Indiana Bank Bldg., Fort Wayne 46802. ◀



## ABSTRACTS, BOOK REVIEWS

### LASERS IN MEDICINE

Leon Goldman, M.D., director, Laser Laboratory, and R. James Rockwell, Jr., Directing Physicist, Laser Laboratory, The Children's Hospital Research Foundation, Cincinnati, Ohio; Gordon and Breach, Science Publishers, Inc., New York, London, Paris; 382 pages, plus index, illustrated.

This is one of the most fascinating scientific works this reviewer has read; but it is not easy reading, owing to the technical difficulty of the subject (including much quantum physics) and to the numerous errors in grammar, spelling and English construction. These latter give the reader pause, but most of them are quickly deciphered or mentally corrected, and the reader then moves on avidly to the next excitement.

For this book is exciting. Since first reading about Light Amplification by Stimulated Emission of Radiation (LASER) in the *Scientific American*, lasers have represented to me a most promising area of the frontier of science, and certain to become useful in medicine. Lasers have already been introduced into industry, into military installations and into science teaching, and, on account of the spectacular properties of this type of light, the public has been given some knowledge of it. On this account, it is greatly to the credit of those engaged in laser biomedical research that they have conducted their work in accordance with the dictum of the American Medical Association that "The presentation (sic) of good medical practice demands that the evolution of therapy be orderly." Except in eye surgery, the use of the laser in medicine is today "still an investigative procedure." Current investigations are in progress *re* cancer, tatoos, birthmarks, wound healing, grafting and bloodless surgery.

Examples of eye conditions treated successfully with lasers are: retinal detachments, especially retinal holes before there is an overt detachment, proliferative diabetic retinopathy, angiomas of the retina, and the chorioretinitis of histoplasmosis. A walking cane using laser radar has been developed to aid the blind. A low-pitched tone activated by a down-pointing beam warns of any drop-off greater than nine inches; a straight-ahead beam, two feet high, with a twelve-foot range, activates a tactile stimulator for the index finger; and the upward-pointing beam warns with a high-pitched tone. Studies have shown the laser radiation from this cane to be well below levels of eye hazard—therefore not dangerous to others.

There appears to be a considerable field developing for "health physicists," not only as technicians in connection with medical lasers, but also as safety engineers in industry, where lasers are now in use for welding and drilling, communications, precise measurement systems, etc. "The laser biomedical engineer will be active in the development of laser biomedical equipment and in all phases of the development of new calibration and maintenance of lasers. This would include establishment of performance standards, safety programs, etc. . . . The program for the birth, care and feeding of this much needed individual who can do much

Continued

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ampicillin, for oral suspension equivalent  
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for advances in biology and medicine should begin now."

The first laser device was announced in 1960; since then some hundreds of different laser systems have been announced, but only about half a dozen are being used in medicine. Each "medium" used in a laser produces characteristic wave-lengths of "coherent" light which have differing effects on living tissue. Much depends on the degree of absorption of the light in proportion to the "reflectance." For instance, a red substance, such as blood, absorbs green light with avidity; therefore, a green laser (argon) would be more effective for coagulating blood in small vessels than a ruby laser. The greater absorption of light means greater absorption of energy, with consequent marked local thermal effects. If tissues involved are not naturally the right color, vital staining with dyes can be used.

Laser beams can be of enormous intensity, with large variation possible by means of different methods and media. It is possible to produce instantaneous bursts of light levels exceeding 300,000,000 watts, but such power is not needed in medicine. For example, in dermatology, for port-wine lesions 55 joules per square centimeter (normal mode, pulsed ruby laser) is required, while for skin cancer, "energy density" for each impact is usually 1500 joules per square centimeter, or larger. Pulse durations in these instances range from 1.0 to 4.5 milliseconds. It is easily seen why highly trained technologists are needed in this field.

One of the most intriguing facets of laser science is holography, or wavefront reconstruction. "The image that results with this technique is an exact three-dimensional replica of the object which, to all appearances, is indistinguishable from the original." Although discovered in 1948, the principle did not become practical until the development of continuous wave gas lasers (1962). This has been further developed in combination with sound waves to produce "acoustic-optical imaging." Experiments with recording acoustic holograms with laser beam scanning have already produced pictures of the skeleton of a fish actually swimming in water. Such pictures have also been made of the bones of the human hand. Power magnitudes for this system can be kept "below the threshold of damage to biological tissue or sensitive mechanical structures." If this technique can be applied to medical study of bones, joints and possibly other human organs while they are functioning, it would have two great advantages over x-ray: 1) the image is three-dimensional, and 2) there is no ionizing radiation.

An amazing "recent discovery by Chen and associates at Bell Telephone Laboratories has shown that holographic information can be stored in tiny crystals of Lithium niobate up to 1000 holograms per crystal. This concept could be most useful as the storage bank for cellular identification." Further, "interference holography is especially exciting" in studies at the cellular level, "observing . . . organelle details . . . and growth patterns of microorganisms . . . and revealing in detail the effects of chemotherapeutic agents, irradiation, etc." "Multicolor and movie holography will be important for medical record systems and for teaching." Holographic 3-D microscopy is just beginning to be used in medicine and biology, and "acoustical holography may be used in tumor diagnosis."

The authors are concerned about safety measures to protect not only the patient but also the operator and attendants. To quote: "At the present time, no one organization or professional group has really accepted the responsibility to

provide professional training regarding laser safety problems. It would seem appropriate for the Health Physics Society to assume this responsibility by educating their members in the aspects of laser safety. Such an effort could provide the whole laser industry with a governing board of informed professionals with prior experience in providing radiation safety criteria and enforcement programs." To give the reader some idea of this problem, the "hazards relate to exposure of the eyes, the skin and, in some applications, the hazards of laser-induced air contamination. . . . There is also concern about laser hazards to the general public since lasers are now finding applications as laser radars, laser transits for construction work, cutting and aligning tools in industry, etc. Thus, the general physician must also learn about lasers and their related hazards."

The reviewer feels that this book deserves the attention of the medical profession and therefore a review as long as this one. It is to be hoped that subsequent publications by these authors will be more carefully written and proofread.

A. W. CAVINS, M.D.  
Terre Haute

## THE PHARMACOLOGICAL BASIS OF THERAPEUTICS

Goodman & Gilman, Fourth Edition, The MacMillan Co., New York, 1970; 1793 pp., innumerable tables and illustrations, twoscore-odd contributors; \$35.00.

In the 30-odd years following its initial appearance, this total review of all that is relevant to "Pharmacology in Therapeutics" has easily attained top rating among its numerous peers. It would be invidious to name the baker's dozen that still grace my shelf. I find, more and more, that—having read Goodman & Gilman—I have no need to look further; my topic of concern has been covered understandably, crisply and incisively, always presenting the latest that is *really* known and never forgetting to state the controversial as well as the still unknown.

In my review of the third edition *JISMA* Aug. 1966, p. 946), I close with a statement that bears repetition in spades: "We doctors can only congratulate them on their product; and proceed to make daily use of their superb achievement."

ARNOLD LIEBERMAN, M.D.  
New York, N.Y.

## UROLOGICAL RESEARCH

Papers Presented in Honor of William Wallace Scott, M.D., Plenum Publishing Corporation, New York, 1972; 222 pp., \$18.50.

This book is called a "Festschrift," a word from the German which is, according to Webster's, "a volume of writings by different authors presented as a tribute . . . especially to a scholar." The scholar in this case is William Wallace Scott who succeeded Doctor Hugh Young at Johns Hopkins and the volume consists of writings contributed by his former senior urology residents at the famous Brady Institute. It took an extraordinary man to replace Young, who was known as the Father of Modern Urology, but Scott is possessed of unusual intelligence and leadership. To quote the introduction of the present work—" . . . those of us within this volume wish to give testimony to the urological center developed, designed and cared for by Dr. William Wallace Scott."

The contents are divided into two sections—Scientific Papers and Highlights. The former includes such diverse titles as “Reflections on the Etiology of Benign Prostatic Hypertrophy” by John T. Grayhack, “Angiographic Characteristics of Renal Hematoma” by Herbert Brendler and John W. Maguire, and an interesting offering by Thomas A. Stamey comparing renal vein renins with differential renal function studies (the renin assay gives more consistent and reproducible results). This names but a few of these articles which are of irregular quality. Some come from the many heads of departments who trained at Brady while some come from recent graduates. The Highlights are subjective accounts of past years of the Brady program with reference to the Chief, Doctor Scott.

A conventional textbook is written in an expository style, which frequently precludes editorial or conversational commentary. The unique quality here in this “Festschrift” is just such discourse. The monograph by Lowell R. King “Technique of Ileal Conduit—Evolution of the Brady Method” is a shining example.

A level of competence is needed to appreciate these nuances and fine points, so urologists from perhaps the senior resident level and beyond will want to read this interesting and inspirational volume.

RODNEY A. MANNION, M.D.  
Michigan City

COMPARATIVE PATHOPHYSIOLOGY OF  
CIRCULATORY DISTURBANCES

C. M. Bloor, Vol. 22, Advances in Experimental Medicine and Biology, Plenum Press, New York, 1972, \$25.

This book is Volume 22 of a series covering Advances in Experimental Medicine and Biology. The book presents results of basic investigation in the field indicated by the title. Outstanding investigators from various fields of medicine and veterinary medicine critically assess animal models that closely resemble human pathophysiological conditions. Sections are devoted to such subjects as comparative pathophysiology of the fetus and neonate, of marine animals, of atherosclerosis and hypertension, and finally, of cardiac disorders. The book has an attractive hard cover. The text is photoprinted from a typed manuscript. Numerous helpful and frequently striking illustrations are included. The book encompasses some 380 pages and sells for \$25. It is recommended not for the usual practitioner, but rather for the individual particularly interested in basic work in this important field.

W. D. SNIVELY, Jr., M.D.  
Evansville

DUNCAN'S DISEASES OF METABOLISM

Sixth Edition, edited by Philip K. Bondy, 35 contributors; W. B. Saunders Co.; in two volumes—1334 pages plus an enormous bibliography, innumerable tables, and illustrations, many in color, \$35.00.

In the 30 years that have elapsed since the first edition came out (1942), progress in this field has been so truly colossal that, I'm sure, Dr. Duncan would be confounded by his brain child's present vast sweep—ever growing! I must make a confession: I read the *entire* two volumes page by page, skipping only over the hundreds of references that close each chapter. A reviewer who has read previous editions

Continued

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can give an opus no higher compliment. Dr. Bondy, in the preface, states the ever-present four variables. With each entity, these are elaborated clearly and succinctly. Congratulations all around.

As a comment on the passing scene, I cannot resist making a purely *social* observation. Towards the end of Volume II, in chapters 26 and 28, Dr. Donald S. McLaren discusses at some length the diseases of UNDER-NUTRITION and AVITAMINOSIS. As illustrations of "kwashiorkor" and "marasmus," Dr. McLaren has ghastly photos of Lebanese and Jordanian infants (pp. 1250, 1251, 1252, etc., also, see pp. 1284 and 1285—again, Arab infants). On page 1251 there is a photo of a Johannesburg Bantu child with the extreme edema that the Germans at the turn of the century used to denominate "mehlnahrschaden." So, Africa is a very prosperous land, indeed: for whites only? And the Russians continue to give the Arabs ARMS but *no* food. It is the USA that furnishes the finances for the UNRRA camps feeding some of the wretches in the various camps. The USSR only arms the Arab elitists for such "glorious" deeds as the Tel-Aviv Lod airport massacre. As a senior citizen, I find my faith in the Lord's infallible decrees a bit strained.

ARNOLD LIEBERMAN, M.D.  
New York, N.Y.



## The value of early fitting

Research has proven the fitting of prostheses on children should be accomplished as early as is practicable. It has only been a few years since the child amputee was not considered ready until just before pre-school age or even later. Extensive experience demonstrates that fitting at a much earlier age produces more effective results.

If there are no complicating factors, children with arm amputations usually should be provided with a passive type of prosthesis soon after they are able to sit alone, generally at about six months of age. Lower-extremity child amputees should be fitted with prostheses as soon as they show signs of wanting to stand. The development of muscular coordination of child amputees is the same as for non-handicapped children; and, therefore, this phase may take place as early as eight months or as late as 20 or more months.

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3004 S. Wayne Ave., Fort Wayne, Ind. 46807

## Abstracts from Various Literature, Prepared by AMA

### STREPTOCOCCAL PHARYNGITIS THERAPY

M. Stillerman et al. (Long Island Jewish Medical Center, New Hyde Park, N.Y. 11040)

*Am. J. Dis. Child.* 123:457-461 (May) 1972.

Cephalexin and K penicillin V were compared in children with pharyngitis and group A streptococci in two consecutive studies in 1968 to 1969 and 1969 to 1970. In the combined studies cephalexin was more effective than K penicillin V ( $P < 0.05$ ).

### DISSEMINATION OF CANCER CELLS BY NEEDLE BIOPSY OF LUNG

R. L. Berger et al. (Univ. Hosp., Boston 02118)

*J. Thorac. Cardiovasc. Surg.* 63:430-432 (March) 1972.

Two cases of malignant pleural effusion produced by percutaneous needle biopsy are reported. The authors suggest that, with operable tumors, possible dissemination of cancer cells into the pleural space may worsen the prognosis and, therefore, needle biopsy is not justified in cases of suspected but operable pulmonary malignancies.

### FETAL SURVIVAL FOLLOWING IMPACT: IMPROVEMENT WITH SHOULDER HARNESS RESTRAINT

W. M. Crosby et al. (Univ. of Oklahoma Health Sciences Center, Oklahoma City 73104)

*Am. J. Obstet. Gynecol.* 112:1101-1106 (April 15) 1972.

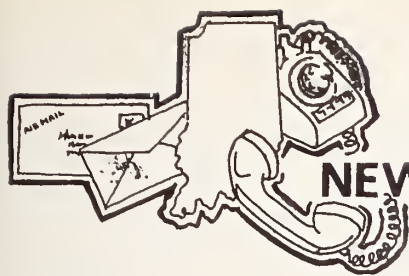
Twenty-two pregnant baboons were subjected serially to impact under similar conditions. The fetal death rate of 8.34% (1:12) among animals impacted with three-point restraint was significantly lower than that of five fetal deaths among 10 maternal animals impacted with lap-belt restraint alone. The high fetal death rate among lap-belted mothers is attributed to forward flexion over the belt and not to deceleration alone. Shoulder harness restraint should be recommended for use by pregnant women as being significantly protective of fetal welfare when compared with the fetal death rate associated with lap belt restraint alone.

### ISOLATION OF RUBELLA VACCINE VIRUS FROM HUMAN PRODUCTS OF CONCEPTION

A. Vaheri et al. (2119 Abington Rd., Cleveland 44106)

*New Eng. J. Med.* 286:1071-1074 (May 18) 1972.

To evaluate the hazard to the fetus of accidental administration of live rubella vaccine during pregnancy the vaccine was given to 35 women who were certified for legal abortion, 24 of whom were seronegative. Rubella virus was recovered from the placenta in six cases and in one case from the fetus. Virus was also found in over 50% of uterine cervix swabs taken 9 to 28 days after vaccination of seronegative mothers; no virus was isolated from comparable specimens from women with pre-existing antibody.



## NEWS NOTES

### Convention Change Announced

**Dr. Peter R. Petrich**, ISMA president, calls attention to the fact that the time for nomination of officers at the 1972 Annual Meeting has been changed. Officers will be nominated at the first meeting of the House of Delegates, Sunday afternoon, October 15.

### Speaks to Rotarians

**Dr. Harold Holwerda**, DeMotte, addressed a luncheon meeting of the Valparaiso Rotary Club recently, giving a slide presentation and talk on the three years he spent as a medical missionary in Nigeria at Takum Christian Hospital with his wife and three children.

### Drug Abuse Films, Tapes Offered

The National Institute of Mental Health has a special series of films and audio tapes designed for health and social service professionals on drug abuse education, prevention and treatment. The aids may be purchased or rented. For full details write National Audiovisual Center (GSA), Washington, D.C. 20409.

### Offer New Booklet on Stroke Rehabilitation

"In a Nutshell: A Guide for Stroke Rehabilitation in the Community Hospital" tells how hospitals, by combining their own existing resources with others in their localities, can provide the early basic care that favors the patient's fullest possible recovery. It is available at 25 cents per copy by writing National Easter Seal Society, 2023 W. Ogden Ave., Chicago 60612.

### Wins Pharmacology Award

**Dr. August Watanabe**, Indiana University School of Medicine, is one of five recipients of the Pharmaceutical Manufacturers Association Foundation awards in clinical pharmacology. His study will be on the effects of drugs on myocardial metabolism. Twenty-four such awards, totaling more than \$1 million, have been granted in this program since 1967.

### Sixteen Films Added to Eaton Library

Eaton Laboratories has added 16 new films to its library of surgical and medical teaching films. All are 16 mm, with color and sound. Fourteen of the new films deal with urology. The Eaton library now contains 132 films. All are available on free loan to medical groups. Write Eaton Laboratories, Norwich, New York 13815.

Continued

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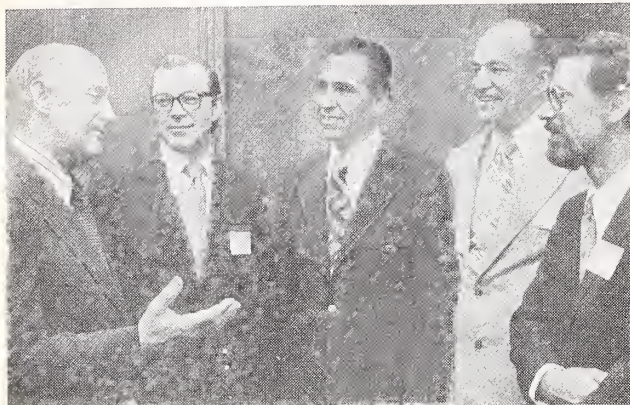
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\*vials for injection equivalent to 1 gm.  
and 5 gm. of carbenicillin.

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DR. Edward Annis, president World Medical Association and past president of the American Medical Association, whose after-dinner speech at the Annual Meeting of the Tenth District Association on May 31 was the highlight of an outstanding meeting, is shown with some of those involved in the success of the meeting. Left to right are Drs. Annis, Petrich, Dimitroff, Ramker and Forchetti.

Dr. Peter Petrich, Attica, is, of course, ISMA president; Dr. Lambro Dimitroff, Calumet City, Ill., serves as Tenth District president; Dr. Daniel T. Ramker, Hammond, is Lake County president; and Dr. John Forchetti, Chesterton, heads the Porter County Medical Society.

## 16-Week PNA Program Announced By Methodist Hospital and IU

Methodist Hospital of Indianapolis and the Division of Continuing Education of Indiana University School of Nursing announce the third and fourth classes of the Pediatric Nurse Associate Program which is offered twice a year in August and February. The program consists of 16 weeks of educational preparation. The 16 weeks are divided into specified blocks of time allotted between the training center and the trainee's own ambulatory child health care setting.

The Pediatric Nurse Associate Program is for the purpose of training registered nurses for an expanded role in providing total health care to children in the community in an ambulatory child health care setting. One of the main goals of the program is to alleviate the shortage of quality medical care to children. The nurse will collaborate with a physician and will be trained to perform some of the duties heretofore performed only by physicians. The presence of a Pediatric Nurse Associate in a physician's office allows the physician more time with patients who need a physician's expertise and skills. In addition, the well child exams can be more promptly scheduled and the Pediatric Nurse Associate can spend more time advising and counseling at these exams than the physician has been able to do.

Applicants must be a graduate of a National League for Nursing accredited School of Nursing and be licensed as an R.N. Experience in pediatrics is beneficial, but others will be given consideration. Nurses presently employed or with an employment commitment from a sponsoring physician will be given preference. A personal interview is mandatory.

Applications are now being accepted for the program with a limit of 15 for each class. Further information can be obtained by contacting: Linda Offutt, R.N., M.S., Nursing Director, PNA Program, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis 46202, (317) 924-8381.

## Anderson Physician on Sixth Viet Nam Tour

Dr. C. Richard Bowers, Anderson, left the country on June 23, on his sixth tour as AMA Volunteer Physician for Viet Nam. More than 700 U.S. civilian physicians have provided more than 900 tours to the provincial hospitals in Viet Nam during the past seven years. They have and will provide service to Vietnamese civilian casualties as well as other patients. Such volunteer physicians also upgrade the health services, teach and advise Vietnamese physicians, and teach Vietnamese medical students.

## State Generic Prescribing Statutes Causing Confusion, Restrictions

Two years ago, the Commonwealth of Massachusetts adopted a generic prescribing law, which was heralded by its backers as the model for the nation. Early claims were that the law, which requires physicians who prescribe a drug listed in the state's drug formulary to include its generic name on the prescription, would improve therapy, reduce costs, and have no untoward effects at all.

In practice, the law has produced great confusion, among both physicians and pharmacists; the prescribing practices of Massachusetts doctors have not changed, and few pharmacists are said to be willing to overtly defy the physician's order for a particular product.

The present consensus is that the law is simply unworkable. Its chances were not enhanced when the chairman of the Massachusetts formulary commission wrote to the New York Times saying that "Backtalk from doctors on this issue is not to (be) tolerated; they've been solidly brainwashed by an ingeniously thorough brand-name pharmaceutical industry which flatters doctors and gives them gifts. Ask your doctor, should he resist, if he realizes how corrupt his profession has unwittingly become."

Meanwhile, a recently enacted Kentucky law introduces two new concepts: The pharmacist is permitted to substitute in the case of any drug listed on a state formulary as being "equivalent." And, if the patient requests the substitution, the pharmacist is required to do so, regardless of his own judgment in the matter. Only if the prescriber writes, in his own hand, the words "Do Not Substitute" is the substitution outlawed.

A Connecticut law now requires generic prescribing, but permits the use of trademarks at the doctor's discretion.

In Maryland, the legislature recently passed a bill that permits substitution of any product listed as equivalent on the Maryland state formulary, no matter how the prescription is written, unless the prescriber specifies otherwise, in writing. In this case, however, there is no requirement that the generic name appear on the prescription. The legislation was adopted over the objections of the Maryland Medical Faculty and the State Board of Pharmacy. One proviso of interest requires that the retail cost of the prescription reflect any cost saving that the pharmacist realized in making the substitution. — **National Pharmaceutical News**, June 1972.

## Dr. Norman Booher Assigned New Responsibilities, Honors

Norman R. Booher, M.D., Indianapolis, who is chairman of the ISMA Commission on Voluntary Health Agencies, has been elected to the vice-chairmanship of the American

Continued





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# He had a nice, normal childhood



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© American Hospital Association    © National Association of Blue Shield Plans

Yes, this fellow, like you, had a perfectly normal childhood. His early life was as simple as a-b-c as well as d.

**a** Hit in head by baseball bat while playing catcher.

**b** Pushed hand through glass storm door chasing kid sister out of house.

**c** Broke arm showing off before golden-haired, 14-year-old Karen Fuller.

**d** Tried to kick football, missed, broke ankle kicking ground.

Kids won't change, but we help make their growing up a lot easier. For them *and* for you.

Blue Cross and Blue Shield stay with you through the years. Day to day, bandage to bandage, all the way.

Always remember, when you're not at your best — we are.

**something to have and hold onto**



(One of a series of ads being run in key Hoosier newspapers)



Medical Association's Council on Voluntary Health Agencies. Doctor Booher was also recently named to the six-member national committee on scouting. The committee is the Sub-Committee on Medicine of the National Advisory Committee on Explorer Scouting. Chairman is John R. Kernodle, M.D., member of the Board of Trustees of the AMA.

Doctor Booher has also been honored by transfer to the status of "Charter" Fellow in the American Academy of Family Physicians.

### Dr. Lehman Promoted

**Dr. David P. Lehman**, Kokomo, has been promoted to the grade of lieutenant colonel in his capacity as surgeon on the staff of the 123rd United States Army Reserve Command, headquartered in Indianapolis.

### NIH Orders Australia Antigen Test

The National Institutes of Health has published an order to require each donation of human blood, plasma or serum used in preparing a biological product to be tested for the presence of hepatitis associated (Australia) antigen. Blood which tests positive may be used only in manufacturing in vitro diagnostic biologicals. All products from either positive testing or negative testing sources must state this fact on the package label.

### Retires from Director's Post

**Dr. J. L. Arbogast**, Indianapolis, has retired from the post of director of the Division of Allied Health Sciences of Indiana University School of Medicine and will remain at school to assist in administrative details of the program. Dr. Jack Lukemeyer will be Acting Director.

### Med School Library Offers Two New Computer Services

The Indiana University School of Medicine Library has initiated two new computer services to provide bibliographies for its patrons.

#### MEDLINE

MEDLINE (MEDLARS On-Line) provides almost instantaneous searching of the medical literature. Its data base consists of about 400,000 citations to articles from more than 1,100 journals indexed since January 1969.

#### SUNY

SUNY (State University of New York Biomedical Communications Network) is also an on-line network. Citations from serials and books are available within minutes on this system. Its data base includes over 1,600,000 citations from MEDLARS (Medical Literature Analysis and Retrieval System) serials articles and book titles from the National Library of Medicine. It can search back to 1964.

If you wish to utilize either of the systems, contact the Reference Department of the School of Medicine Library. If you are a local patron, please present your query in person. If you live outside the Indianapolis metropolitan area, contact your local public library and your request will be relayed to this library via the statewide TWX network. For physicians outside Marion County copies of the articles listed in the bibliographies will be supplied by the School of Medicine Library. Physicians in Marion County may borrow the articles in the original.

### Rehabilitation Center in Operation

Regrettably, The Journal failed to make mention of the fact that the Rehabilitation Center of Methodist Hospital of Gary, Inc., opened on January 3, 1972, and is believed to be the only comprehensively planned rehabilitation center in the state.

**Anatol Lytwakiwsky, M.D.**, the medical director, specializes in Physical Medicine and Rehabilitation.

Patients of all ages and from all walks of life may be accepted for both in and out-patient services, upon referral from their family physician, a state or federal agency, and the approval of their application by the Center's medical director.

### Scandinavian Medical Tour a Success

A Scandinavian medical tour was successfully conducted by the Indiana State Medical Association May 24-June 7 under the chairmanship of Dr. Peter R. Petrich, Travel Committee, and Dr. W. P. Loh, Medical Seminar Committee. More than 140 physicians and their families participated in the tour, which was one of 20 Scandinavian medical tours involving 14 state and county medical societies.

Dr. Loh served as medical program chairman for the 20 Scandinavian tours and more than 60 additional medical tours for Africa, Orient and Mediterranean countries. 1973 editions are already being arranged and will include South Pacific medical tours beginning January for New Zealand, Australia and Tahiti and European medical tours beginning June for Germany, Austria and Switzerland. All travel arrangements are made by the INTRAV of St. Louis and each tour lasts two weeks.

One trustee of our state association, Dr. William Clark, and family, was in our group. We traveled by a World Airways chartered jet and spent four days each in Sweden, Finland and Denmark. Extended trips to Oslo, Norway and Leningrad, Soviet Union, were made by many of us.

The medical program was superb. Hospital visits and ward rounds were conducted in Stockholm, Helsinki, and Copenhagen. Many interesting and authoritative lectures were attended in the same cities. Subject matter of the lectures was varied and matched the varied interests of our multiple-specialty group.

WEI-PING LOH, M.D.  
Gary



WARD rounds at Helsinki University Central Hospital, Finland.

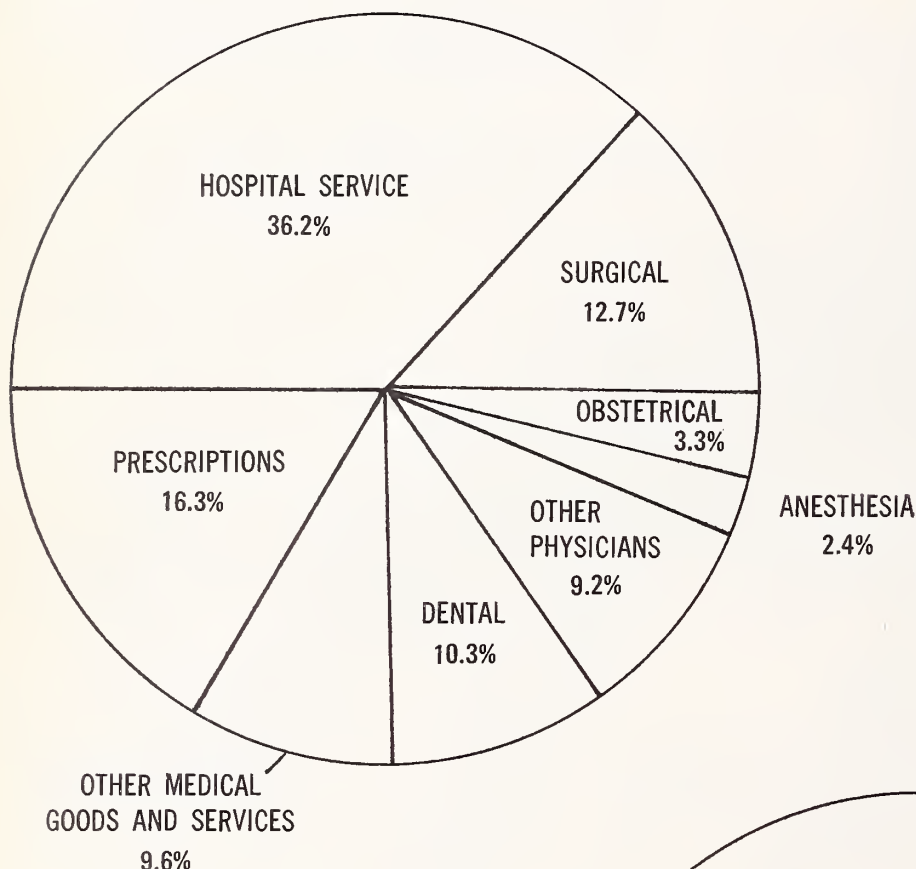


# Charting the Indiana Health Care Dollar

## Indiana's 1971 Health Care Bill

\$1,390,000,000

(Estimated)



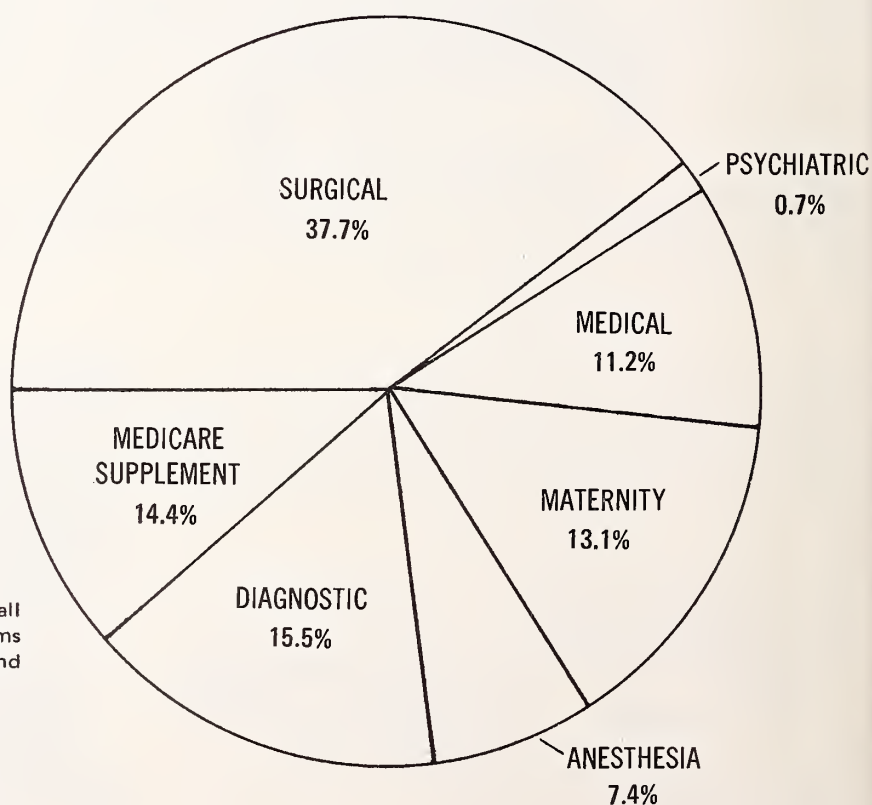
The chart at the upper left represents the estimated distribution of the 1971 Indiana Health Care Bill, and the one at the lower right shows the percentage division of the 1971 Indiana Blue Shield dollar.

Hospital service took the biggest slice of last year's estimated Indiana Health Care bill, with approximately 36.2%, or \$513,180,000 of the total amount. The distribution is based on a total figure of \$1,390,000,000. Prescriptions claimed the next largest portion with a percent of 16.3 and an estimated expense of \$226,570,000.

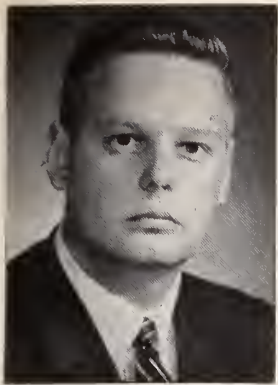
The 1971 Indiana Blue Shield dollar distribution shows 37.7% of the bill going for surgical, while diagnostic is the second largest payment with a 15.5% figure. Surgical payments amounted to \$20,277,389.48 while diagnostics were \$8,336,857.74 of the overall figure of \$53,786,179.63.

## 1971 Indiana Blue Shield Dollar

\$53,786,179.63\*



\*excludes incurred and pending claims for all business at the end of 1971, and paid claims under the Prescription Drug, Major Medical and Federal Employees programs.



## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

The reasons for waiting until the last quarter of a calendar year (October - December) to make *all* of your gifts are beginning to add up. I've mentioned some reasons in the past, and now, another significant reason has become apparent. That is, due to a recent change in the federal gift tax laws it is possible to lose part of the marital deduction to which donors are entitled when they make gifts to their spouses.

A simple example can illustrate the point. As you probably know, an individual is entitled to a gift tax marital deduction for gifts made to his spouse. In general, the amount of the deduction is one-half the amount of the total gifts (before any exclusion) that are made to a spouse during any calendar quarter. Thus, if an individual makes a gift of \$20,000 to his wife during a calendar quarter, the donor is entitled to a gift tax marital deduction of \$10,000 ( $\$20,000 \times 50\%$ ).

However, I.R.C. section 2524 imposes one limitation upon the amount of the marital deduction—for each quarter. That is, a donor may not take a marital deduction for more than the *amount* of the gifts to his spouse that were included in the donor's gross gifts, i.e., total gifts less exclusions. In

the above example there is no problem, because the marital deduction is \$10,000 and the limitation is \$17,000 ( $\$20,000 - \$3,000$ ). Thus, the entire \$10,000 is deductible.

But suppose that a donor makes gifts of \$4,000 to his spouse during one quarter. Then, his total gifts would be \$4,000. His gross gifts would be \$1,000 ( $\$4,000 - \$3,000$ ). And, his marital deduction would be \$1,000 (50% of  $\$4,000 = \$2,000$ , but limited by gross gifts of \$1,000, namely,  $\$4,000 - \$3,000$ ). This much has always been true under the gift tax laws.

However, assume that this latter individual made another gift of \$4,000 to his spouse during the same calendar year, but during a different quarter. For the next quarter, the donor would compute his taxable gifts as follows.

Total gifts	\$4,000
Less exclusions	-0-
Gross gifts	<u>\$4,000</u>
Less marital deduction	<u>2,000</u>
Taxable gifts before \$30,000 exemption	<u><u>\$2,000</u></u>

On the other hand, if the donor had made all the gifts during the same quarter, then his gift tax computation would have been as follows.

Total gifts	\$8,000
Less exclusions	3,000
Gross gifts	<u>\$5,000</u>
Less marital deduction	<u>4,000</u>
Taxable gifts before \$30,000 exemption	<u><u>\$1,000</u></u>

Thus, because the donor made "small" gifts to his spouse in more than one quarter of the same calendar year, his taxable gifts were \$1,000 higher before considering his \$30,000 exemption.

Advice: Before making any gifts

to your spouse—ask your lawyer to comment on the tax result. And, if possible, try to make all your gifts during the same quarter of a calendar year.

The I.R.S. has just issued a ruling that is not particularly startling, but it will provide comfort to many lawyers and to their corporate clients which have professional or other service-type employees. This ruling (based upon the prior Rev. Rul. 55-81) provides that a pension plan that otherwise meets all the applicable requirements for qualification under I.R.C. section 401(a) will not be disqualified merely because the plan is established by a corporation that is operated for the purpose of selling the services, abilities, or talents of its only employee, who is also its principal or sole shareholder. See Rev. Rul. 72-4, I.R.B. 1972-2. ◀

### Private Practices

\$40,000 minimum collections guaranteed first year, payable monthly. Not a loan. Need general practitioners, internists, OB/GYNs, anesthesiologists, and orthopedists in many states. Practices available for 1972-73-74. Not an employment agency. No cost to physician to investigate practice. Write or call Sanford Smith, Director of Physician Planning, Hospital Affiliates, Incorporated, P.O. Box 9836, Houston, Texas 77015. 713/453-6324.



# *The Woman's Auxiliary* REPORTS TO ISMA

The Woman's Auxiliary to the AMA received a special tribute at the opening session of the AMA's House of Delegates held recently in San Francisco. This program highlighted the 50th anniversary convention of the auxiliary and featured an audiovisual, multi-media presentation, preceded by a musical tribute to the M.D.s and a 1920s style show by auxiliary models. The film sketched 50 years of achievements, including the founding in 1922, the growing involvement of the auxiliary on politics and legislation, auxiliary leadership in sponsoring Health and Careers Clubs, and the raising of more than \$6 million since then for nursing and allied health career scholarships and loans.



During the opening meeting, Mrs. G. Prentiss Lee, National auxiliary president, presented a check for \$740,388 to John M. Chenault, M.D., President of AMA-ERF. This marked the auxiliary's largest single contribution. Since 1951, the auxiliary has raised \$5,487,388 for AMA-ERF which provides unrestricted grants to medical schools and enables medical students, interns and residents to obtain loans.

The meetings Monday were highlighted by a luncheon honoring the AMA officers, trustees and wives, at which Art Linkletter was the guest speaker.

"Use a little pillow talk to remind your husbands that they have a huge responsibility every time they prescribe a psycho-active drug," he told the more than 600 guests at the luncheon. He urges the physicians' wives to campaign for realistic drug education in the schools, starting in kindergarten, and to launch a drive to have hospitals make room for

addicts and treat them like sick people, not criminals.

The reports on the activities of the state auxiliaries for the past year were in the form of an idea exchange. It is always interesting to hear what other states are doing and to realize that we in Indiana can keep up with the best of them. Lelia Chernish reported on the fledgling Nursing Home Visitation project which was instituted in Indiana last year. So far as we could ascertain, we are the only state to undertake such a program as of this date.

Dr. Edward Stainbrook, head of the Human Behavior department of U.S.C. School of Medicine spoke on "How to Survive the Future."

"There are cries of anguish about the rapid changes of life style and values, such as children living together without being married, the communes and the global hitch-hiking. This is really mourning for loss of familiar life styles that are gone forever, and you'd better believe it.

"Stop suppressing dissent and start getting into a frame of mind to let youth express itself constructively," said Dr. Stainbrook. He thinks the auxiliary can be a tremendous force in changing the education system.

Mrs. Robert F. Beckley of Lock Haven, Pa., was installed as president of the auxiliary on June 21. In her inaugural remarks, Mrs. Beckley urged the auxiliary to "press for improvements that will overcome criticism of the profession and help improve the Quality of Life for all."

Indiana was fully represented by the eight delegates and one presidential delegate that we are allowed. Mrs. Stanley Chernish was presidential delegate; others were: Mrs. Philip Smith, Fort Wayne; Mrs. Willis Stogsdill, Indianapolis; Mrs. Malcolm Scamahorn, Pittsboro; Mrs. Jack Shields, Brownstown; Mrs. G. Beach Gattman, Elkhart; Mrs. Jack Walker, Yorktown; Mrs. Kenneth Neumann, Lafayette; and Mrs. Eugene Rifner, Van Buren.

*Marjorie Smith*

## FUTURE MEETINGS, SEMINARS, COURSES

### Malpractice Course Offered

A course on Medical and Dental Malpractice will be conducted by the Practising Law Institute at the Essex House, New York City, on September 1 and 2. Fee for the course is \$100. Write the Institute at 1133 Avenue of the Americas, New York City 10036.

### Cleveland Clinic Schedule Given

Postgraduate courses to be given at the Cleveland Clinic within the next few months have been announced, as follows:

"Medical Technology," Dr. J. King, Sept. 28.

"Clean Air Symposium," Dr. C. Nelson, Nov. 10.

"Gastroenterology: Current Topics," Dr. R. Farmer, Nov. 15 and 16.

"Current Concepts in Ophthalmology," Dr. F. Gutman, Dec. 6 and 7.

For tuition cost and further information, write to the Cleveland Clinic Education Foundation, 2020 E. 93rd St., Cleveland 44106.

### Rhinologic Society, LSU To Present Workshops

The American Rhinologic Society and Louisiana State University School of Medicine will present workshops and seminars on Respiratory Physiology, Rhinomanometry and Corrective Nasal Surgery September 19 to 21 at New Orleans. Write for details by addressing Dr. Gerald F. Joseph, 3622 Government St., Baton Rouge, La. 70806.

### U of Colorado to Conduct Hospital Medical Staff Meet

The Hospital Medical Staff Conference will be conducted by the University of Colorado School of Medicine at Estes Park, September 24 to 29. It is open to physicians who are or will be in leadership roles in community hospitals. Much of the material presented will be the same as or similar to previous conferences in this series. Repeat attendance is discouraged. For full details write to Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

### ACEP to Meet at San Francisco

The American College of Emergency Physicians will conduct its Fourth Annual Scientific Assembly at the San Francisco Hilton Hotel November 8 to 10. Emergency Department Medicine and Management will be the theme of the scientific program. Non-members will pay \$85 advance registration fee or, if registering after October 1, will pay \$90. For full details write the College at 241 E. Saginaw St., East Lansing, Mich. 48823.

### Course in Laryngology and Bronchoesophagology Set

The Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, will conduct a continuing education course in Laryngology and Bronchoesophagology November 13 through 18, 1972. The course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians will please write directly to the Department of Otolaryngology, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

### Battered Child Subject of Conference in Colorado

"Innovative Approaches to Prevention and Treatment of the Battered Child Syndrome and Development of Community Programs" is the subject for a conference to be held at Denver on November 27 and 28, under the auspices of the University of Colorado School of Medicine. The tuition for the two days is \$60. Detailed programs will be available in September. Write the Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

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### Errata

The names of the following full-dues-paying members were inadvertently omitted from the June 1972 Roster. The **Journal** regrets any embarrassment or inconvenience caused by the error. The names which should have appeared are:

Robinson, Nan, M.D. (Floyd), 1726 State St., New Albany 47150 (PD)

Voskuhl, William L., M.D. (Clark), 935 Water St., Charlestown 47111 (GP)



# Continuing Education For Physicians

## POSTGRADUATE COURSES IN INDIANA—IUSM

### **Coronary Care Concepts and Practices — Indianapolis** **September 6-7, 1972, January 17-18, 1973**

The course is designed for physicians desiring further training in the diagnosis and management of patients with acute myocardial infarction. Areas of emphasis will include the clinical and patho-physiologic aspects of coronary artery disease, practical experience in monitoring techniques, and interpretation of the electrocardiogram. Special focus will be on recognition of cardiac arrhythmias and the pharmacologic and electrical management of rhythm disturbances. (Marion County General)

### **Clinical Dermatology — Indianapolis** **September 20, 1972**

The postgraduate program in Clinical Dermatology will be presented by the members of the Department, both at the University and those in private practice. Each speaker will be limited to five minutes and his subject must be one with which he is frequently confronted in the office. All presenters will emphasize therapy and management of the common dermatoses. Ample time is allotted for questions and discussion by those attending. (IUSM)

### **Urology Today: Problems at Both Ends of Life's Spectrum — Indianapolis** **September 22, 1972**

"Medical advances in general have accrued particularly to the very young and old patients seen by urologists. Newer diagnostic techniques, better understanding of fluid and electrolyte management, drug therapy, and better controlled follow up data have shed new light on a number of childhood and adult diseases seen by all doctors. Special emphasis is given to diagnosis and management of infections, and the study and treatment of their causation. Also practical aspects of clinical oncology, immunity, transplantation, fertility control, and infertility investigation, and sexual problems of the physically handicapped will be reviewed with expert guest panels. It promises to be a lively updated program." (Atkinson Hotel)

### **Venereal Diseases — Indianapolis** **September 27, 1972**

Venereal disease is becoming the nation's fastest growing social health problem. It outranks alcoholism and drug abuse. The federal government has placed new emphasis on its control and eradication by making V.D. a priority in funding health programs. The September conference is directed at bringing information to practicing physicians on current trends in V.D. Control (diagnosis, treatment, epidemiology and education). (IUSM)

### **When, Why and How in Everyday Cardiology — Indianapolis** **October 2-4, 1972**

The program is oriented toward solving problems faced in the everyday practice of cardiovascular medicine. Patient evaluation and management, procedural indications, thera-

peutic problems and the relationship of the patient with cardiac disease to society and concomitant medical conditions will be discussed from the clinical point of view. There will be time for the enrollees to consult concerning their specific problems during the panel sessions. (Marion County General)

### **Management of Trauma: Current Practices and Prospects — Indianapolis** **October 27, 1972**

This one-day course has been designed to review the current methods of managing the acutely injured with emphasis on the practical details involved. Future prospects for improved transportation and management of the injured will be presented. (IUSM)

### **Clinical Neuro-Ophthalmology Symposium — Indianapolis** **November 1, 1972**

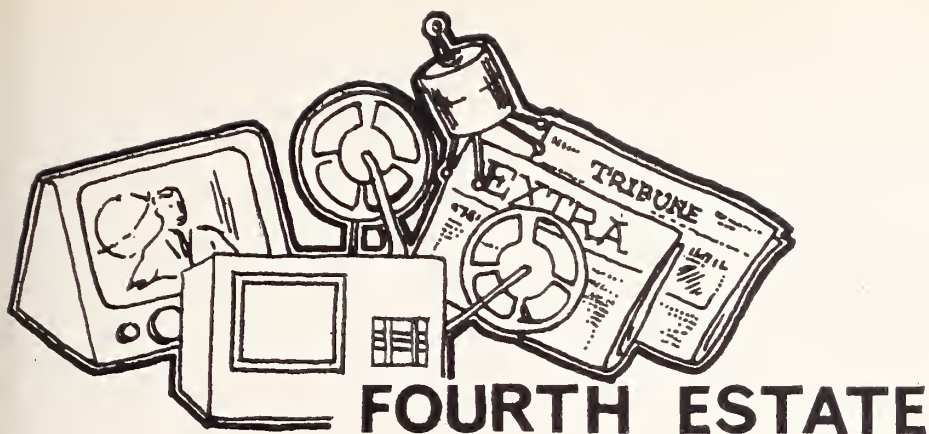
The Clinical Neuro-ophthalmology Symposium is a meeting designed for ophthalmologists, neurologists, neurosurgeons, and other physicians interested in neurological disorders of the oculomotor and visual systems. The session will be entirely clinically oriented and will include presentations of both common and unusual neuro-ophthalmology problems. The diagnostic evaluation and treatment of each patient will be discussed. Questions from the audience as well as their participation in the discussions will be encouraged. (Methodist, Indianapolis)

### **Forensic Pathology and Toxicology — Indianapolis** **November 15, 1972**

The course will cover the contributions Pathology and Toxicology can make in the solution of medical-legal problems. Toxicology will cover the collection, preservation and handling of body tissues and fluids appropriate for analytical screening for drugs and poisons; interpretation of analytical findings and emergency diagnosis and treatment of intoxicated patients. Forensic Pathology will include a discussion of sudden and unexpected death involving chemical or physical trauma. (IUSM)

### **New Concepts in the Diagnosis and Treatment of Hypertension — Indianapolis** **November 21, 1972**

The course will deal with the diagnosis and treatment of patients with various types of hypertension, in light of recent knowledge. It will emphasize the forms of hypertension which are associated with abnormalities in plasma renin levels. Particular attention will be given those forms of hypertension which can be differentiated from "essential" hypertension, and for which specific medical or surgical treatment modalities can be offered. The Faculty will be composed of staff from the Specialized Center of Research in Hypertension at Indiana University Medical Center and distinguished visitors from other centers. (Indianapolis Hilton) ◀



This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Of Morals and Medicine

Should suicide laws be repealed? Mercy killing be removed from statutes prohibiting homicide? Are we prepared to take affirmative steps toward reducing the number of genetically defective individuals and hopefully eliminate some genetically transmitted conditions?

These are a few of the questions posed in a recent editorial in the *Journal of the American Medical Assn.* The Judicial Council of that organization has decided to provide leadership in seeking solutions to such urgent and troubling ethical,

social and legal dilemmas which have, ironically, resulted from the extraordinary advances in medicine and biology in recent years.

The AMA has named a group of eminent consultants to their advisory committee. To be focused on are six major topics of concern: abortion, technology of reproduction, behavior control, genetic engineering, human experimentation and euthanasia.

"These are not questions of medical ethics to be answered solely or exclusively by physicians. They are ethical issues of society . . . Physi-

cians advise, offering the benefit of their expertise, their knowledge, competence and experience."

But even with the best of talent and efforts it is not likely as the journal's editorial admits, that clear-cut answers will be found to these ethical issues.

If, however, the AMA and its committees can organize and effectively transmit information to the public, they will have performed a considerable service in clarifying the issues in these areas that daily gain in significance.—*Madison Courier*, April 14, 1972.

## The Suemna Coleman Home

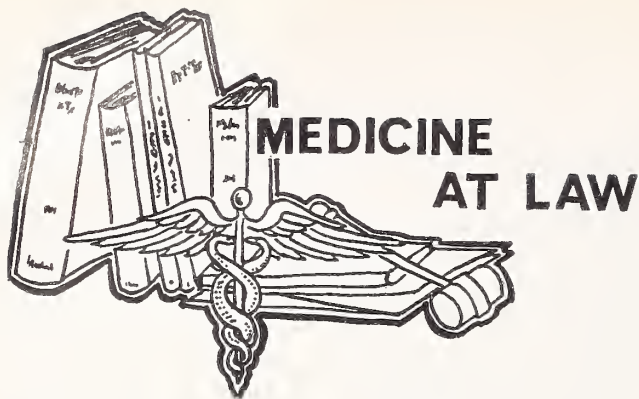
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**Patient Cannot Claim Privilege in Malpractice Case** — A patient in a medical malpractice action may not refuse to answer pretrial questions on the basis that the information sought is privileged, according to a recent decision of an Ohio trial court. The physician-patient privilege was distinguished in this case from that involving disclosure where some third person is a party to the litigation.

The patient's malpractice complaint stated only legal conclusions; no facts were alleged. The physicians being sued then attempted to discover the basis of the patient's claim, but their questions were not answered because the patient claimed that communications with his physicians were privileged.

The physician-patient privilege does not apply to actions where the doctor is being sued. In cases of this kind, due process of law requires disclosure. The purpose of privileged communication between a physician and his patient does not exist where a third party is not involved.—*Otto v. Miami Valley Hospital Society of Dayton, Ohio, Inc.*, 266 N.E. 2d 270 (Ohio Ct. of Common Pleas, Jan. 18, 1971).

**Negligent Physician not Released by Release of Auto Driver** — After an automobile accident, release of an allegedly negligent driver did not release a physician alleged to have been negligent in treatment of injuries sustained in the accident,

the Georgia Supreme Court ruled. Where the alleged wrongs were successive, rather than joint, release of one party did not release the other unless all damages were paid in full or unless the parties intended to release both the driver and the physician.

The case involved a minor who sustained serious and permanent injuries in an automobile accident. He was treated by a neurosurgeon for a little over a month. The boy's parents executed a release in favor of the driver and the owner of the automobile involved in the accident, their insurance carrier, and "all other persons." They received payment of \$10,500. The physician was not named on the release form signed by the parents.

The parents filed suit for negligence against the physician, contending that he had been negligent in failing to diagnose and remove a subdural hematoma which developed during the course of treatment. Such failure allegedly caused further injury to the boy's brain.

The physician moved for summary judgment, contending that the action was barred by the release. The trial court granted the motion, the parents appealed, and the appellate court affirmed the trial court.

The state supreme court pointed out that the physician and driver did not act in concert to produce a single injury. Instead, the physi-

cian's alleged negligence, although contributing to the overall damage, was subsequent to the original injury and created a separate cause of action.

The court said that it was up to the parents to show that the settlement did not compensate them in full. The father had asserted in an affidavit that medical and other expenses for his son were in excess of \$37,000.

Taken at face value, the court said, the release freed the physician from liability. However, the physician was not a party to the agreement between the parties, contributed nothing to the settlement, and was not named in the release. Therefore, the court saw no reason why he should share in the benefits conferred by the release unless such was the intention of the parties. Reversing the judgment of the lower court, the supreme court held that the burden was on the parents to show that the physician was not included in the release.—*Knight v. Lowery*, 185 S.E.2d 915 (Ga. Sup. Ct., Dec. 2, 1971; rehearing denied, Dec. 17, 1971).

*Editor's Note:* A prior decision was reported in THE CITATION, Vol. 24, No. 10, p. 149.

**Medical Center Owner Liable for Surgeon's Negligence** — A physician who owned a medical center was liable for the alleged malpractice of a surgeon using the services of the center, a Michigan appellate court ruled. Although an independent contractor, the surgeon conducted himself as a member of the center and sent out bills on the center's stationery.

When a 5-year-old girl was injured in an automobile accident, the owner of the medical center examined her and referred her to the surgeon for application of a cast. Her mother took her to the medical center six weeks later for cast removal. The surgeon used a vibrating

wheel, which he later testified did not turn but removed a cast by vibration. He also testified that a finger placed directly on the wheel would not be cut.

Shortly after the surgeon began removing the cast the girl started to scream. Although the mother told the surgeon to stop because the girl was being hurt, he insisted she was merely frightened and proceeded to remove the cast. When he was finished, deep bleeding cuts were revealed. The surgeon treated the cuts and told the mother to bring the child back for further treatment if necessary.

Suit was brought against the surgeon and the owner of the medical center. Before trial the suit against the surgeon was dropped under an agreement not to hold the surgeon personally liable for any malpractice. The trial court found that the patient had met the burden of proof as to malpractice against the surgeon and that the owner of the center was liable for the surgeon's acts.

There were 33 physicians associated directly with the center, six of whom maintained offices there. Patients were often billed by the center. The surgeon had an office there and was called on by the center for surgical services. He and other physicians paid the center 50% of their charges in return for use of the facilities.

On appeal, the court said that, although the surgeon was an independent contractor, the owner of the center could incur liability for

the surgeon's negligence on the basis that patients could reasonably conclude that he was an agent of the center.

In order to recover damages for alleged acts of an ostensible agent, the person dealing with the agent must reasonably believe in the agent's authority, the court said. Such belief must be generated by an act of the principal who is charged with liability for the agent's acts, and, in relying on the agent's apparent authority, the person dealing with the agent must not be guilty of negligence.

The child had been personally referred to the surgeon by the owner of the center. She was treated entirely at a hospital where the surgeon performed as a member of the center. Further, her treatment was billed through the medical center on center stationery with the surgeon's name on it. The court said that there was no reason for the mother to think that the surgeon was not an employee of the center.

Affirming the judgment of the trial court, the court said that, although the surgeon testified that a finger placed on the wheel would not be cut, the fact that the child was cut when the vibrating wheel was used was sufficient for the trial court to find the surgeon guilty of malpractice.—*Howard v. Park*, 195 N.W.2d 39 (Mich.Ct. of App., Jan. 17, 1972; rehearing denied, March 3, 1972).

**Award of \$575,000 for Death from Postoperative Ileus — The**

family of a patient whose death resulted from a postoperative ileus was awarded \$575,000 by a California jury. In a suit against the physician and the hospital, the family claimed that the physician had failed to promptly diagnose and treat the ileus. The hospital allegedly failed to summon another physician when it became apparent to the nursing staff that the treatment being rendered by the physician was ineffective. The patient's family also claimed that the hospital failed to follow all of the physician's orders.

The patient had been admitted to the hospital for the removal of a small cyst from his kidney. After the operation, he developed an adynamic, or paralytic, ileus. He died six days after the operation. The immediate cause of death was the aspiration of the patient's own vomitus. An autopsy revealed a massive adynamic ileus.

The medical experts agreed that a patient would not die as the result of a postoperative ileus if standard medical practice were followed. The physician and the hospital contended that the ileus was an infectious process and was not caused by the operation. The hospital also claimed that the physician advised them not to be concerned with the patient's condition.

The trial court instructed the jury as to the *res ipsa loquitur* doctrine. — *Carlo v. Hutch* (Cal. Super.Ct., Contra Costa Co., Docket No. 118707, Dec. 15, 1971).

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# The Cooper Quiz – Answers

JAMA, March 6, 1972

1. (a)

"Bernstein and coworkers studied the x-ray films of persons in high and low fluoride areas in North Dakota, finding osteoporosis to be substantially more frequent in the low fluoride area. These authors incidentally noted that there were significantly fewer calcified aortas visualized in the roentgenographs of those persons residing in the high fluoride area."

(March 6, 1972, pp. 1310-1311, col. 3, para. 1)

2. True

"Our finding of a strong association between osteoporosis and calcification of the abdominal aorta suggests that there is no clear separation between local 'dystrophic' aortic calcification and systemic metastatic calcification. It also suggests that the roentgenographic demonstration of calcification of the abdominal aorta may not be an accurate reflection of the severity of aortic atherosclerosis, but may depend equally, or even more, upon the presence of osteoporosis. Perhaps the long-continued loss of calcium from bone into the extracellular fluid predisposes to aortic calcification, being more manifest in previously damaged aortic areas."

(March 6, 1972, p. 1311, col. 2, para. 3)

3. False

"Two pediatric screening clinics staffed by students and community volunteers were conducted in low - income, Spanish - American neighborhoods in Albuquerque, N. M. The program was designed to

examine preschool children by means of history, physical examination, hematocrit, urinalysis, and psychological tests. Three hundred and fifty-two children were examined. Abnormalities in the results of laboratory tests or physical examination were identified in 59(17%). Information on the results of further evaluation of suspected abnormalities is incomplete but suggests that approximately 5% of the children had chronic physical impairment and that 7% had significant emotional or mental impairment."

(March 6, 1972, p. 1315, "Abstract")

4. True

"Even with our present criteria, it appears that the major value of FHR monitoring lies in the prediction of an apparently normal neonate regardless of the level of his heart rate. Our ability to predict neonatal outcome by using FHR observations obtained within a 30-minute interval between the end of monitoring and the delivery, coupled with the fact that we have not encountered a **sudden** transition from normal to very ominous patterns, suggests that in the absence of some obstetrical catastrophe babies do not deteriorate as rapidly as once was supposed. Despite the widely held belief that sudden death may occur during labor in fetuses with normal heart rate (as determined clinically), not a single case of unexpected fetal death has been documented in a monitored fetus.

"The high correlation between predicted and observed

neonatal outcome, as reflected by the Apgar score, has contributed to the growing feeling here that FHR monitoring is of clinical value in routine obstetrical care. We have developed confidence that a normal pattern indeed reflects adequate fetal reserve. . . . In addition to affording us insight into fetal responses to obstetrical anesthesia, the influence on neonatal care has been dramatic. In anticipating neonatal distress from FHR patterns, resuscitation of the newborn has become better organized and the quality of neonatal care has been improved. Although it was not an objective of this study, we believe that we have clearly demonstrated both the feasibility and the intrinsic worth of routine fetal monitoring."

(March 6, 1972, pp. 1324-1325, col. 3, para. 2)

5. True

"Catamenial pneumothorax appears to be a specific clinical entity. The following features are common to all cases: (1) involvement of the right hemithorax; (2) a close temporal relationship between the cyclic occurrence of pneumothorax and the onset of the menstrual flow; (3) failure of pneumothorax to occur at other times in the menstrual cycle; (4) relatively late onset of the disease (the majority of patients had the onset of symptoms in the fourth decade of life); and (5) failure of pneumothoraces to occur if the patient is pregnant or is taking ovulation-suppressing drugs. Clinical features found in some (but not all) patients with catamenial pneumothorax include (1) clinical or pathologic evidence of pelvic endometriosis); (2) pleural or diaphragmatic endometrial implants; (3) perfora-

tions in the right hemidia-  
phragm; (4) failure to find a  
pulmonary source of potential  
air leakage at thoracotomy; and  
(5) failure of thoracotomy  
(with or without resection of  
blebs) to prevent further re-  
currences of pneumothorax,  
particularly if pleural ablation  
was not performed.

"The etiology and patho-  
genesis of catamenial pneumo-  
thorax are still poorly under-  
stood, although it can scarcely  
be doubted that the presence of  
endometriosis must play a role  
in most (and, perhaps, all)  
cases."

(March 6, 1972,  
p. 1331, col. 2, para. 5)

**JAMA, March 13, 1972**

6. False

"Of all factors analyzed in  
this paper, age of the patient is  
the single predictor of prognosis  
in hospitals. The abrupt of  
change in prognosis for patients  
older than age 60 years seems  
worthy of emphasis. This 'break-  
point' phenomenon should be  
appreciated by the investiga-  
tor using mortality as a measure  
of effect of prophylactic or  
therapeutic intervention. The  
high admission frequency on  
Mondays and the relatively  
constant fatality percentage on  
each day may reflect behavioral  
factors associated with week-  
ends that trigger incipient cases  
into manifest ones."

(March 13, 1972,  
p. 1427, col. 2, para. 3)

7. False

"Paton found abnormalities  
of the conjunctival vasculature  
in almost all cases of sickle  
cell disease and considered  
them pathognomonic of this  
condition. He described 'multi-  
ple, short, comma shaped or  
curlicued capillary segments of-  
ten seemingly isolated from the

vascular network.' These ab-  
normalities were generally  
marked in SS, mild in SC, and  
equivocal changes occurred in  
some patients with the sickle  
cell trait. The intensity of ab-  
normal vessels varied in pa-  
tients with SS but the only  
cases with normal capillaries  
were young children with high  
hemoglobin F levels or adults  
after transfusion. In the latter  
case, abnormalities returned as  
the effects of transfusion disap-  
peared. On the basis of these  
observations, Paton suggested  
that the intensity of the sign  
was related to the degree of  
sickle cell formation in an in-  
dividual patient."

(March 13, 1972,  
p. 1428, col. 1, para. 2)

...

9. True

"The Wilford Hall outbreak  
shares many features with an  
illness variously known as Ice-  
land disease, benign myalgic  
encephalomyelitis, and epidem-  
ic neuromyasthenia. That dis-  
ease also occurs in outbreaks  
among hospital personnel, has  
a relapsing course, persists over  
many months, and has frustrat-  
ed efforts to incriminate a path-  
ogen. Gastrointestinal symp-  
toms may precede the onset of  
neuromuscular symptoms. The  
latter include stiff neck, ex-  
treme weakness, myoclonic  
jerks, marked muscle aching  
and tenderness, cutaneous dy-  
sesthesias, depressed sensorium,  
and personality changes. Physi-  
cal findings have included low  
grade fever, conjunctivitis, pos-  
terior cervical adenopathy, and  
vesicular stomatitis. The clini-  
cal and epidemiological features  
of the Wilford Hall illness  
strongly suggest that this was  
an outbreak of epidemic neuro-  
myasthenia. Diagnostic efforts  
by others have very tenuously

implicated organic mercury  
contact and Bethesda-Ballerup  
paracolon bacteria isolated  
from the stools of patients. Our  
diagnostic studies supported  
neither of these factors as path-  
ogens."

March 13, 1972,  
p. 1442, col. 1, para. 2)

10. False

"We have described three  
patients, all of whom had nor-  
mal urine volumes prior to  
lithium carbonate therapy but  
developed polyuria and poly-  
dipsia after being treated with  
lithium carbonate. None of the  
patients had evidence of sig-  
nificant medical illness prior to  
or after being placed on a  
regimen of lithium carbonate.  
They all had a good therapeutic  
response to lithium carbonate.  
None of the patients had evi-  
dence of kidney disease or of  
conditions which predispose to  
renal concentrating defects. All  
of the patients were polyuric  
in the presence of therapeutic  
plasma lithium ion values, and  
there were no other features of  
toxic effects of lithium car-  
bonate.

"The renal concentrating de-  
fect varied from an almost com-  
plete inability to concentrate  
urine for patient 1 to a partial  
defect for patients 2 and 3. For  
instance, patient 2 increased his  
urine concentration to 554 mOsm/kg after receiving vasopres-  
sin. This increase probably in-  
dicates some ability to respond  
to vasopressin, but the value is  
much less than the 800 mOsm/kg or more that would be ex-  
pected in a normal subject. It  
is not yet clear whether a par-  
tial defect progresses to a more  
severe form, whether the con-  
dition tends to remain relatively  
stable, or whether normal con-  
centrating ability may return  
while patients are still receiving



lithium carbonate therapy. The patients reported by Angrist et al seemed to regain concentrating ability, as measured by urine volume and specific gravity, within three to four weeks after lithium carbonate was stopped."

(March 13, 1972,  
p. 1448, col. 2, para. 4)

# JAMA, March 20, 1972

11. (g)

"Three cases of reticulum cell sarcoma occurred in 151 renal allotransplant recipients during the course of 438 patient years of survival, an incidence of 0.7% per year. This incidence was more than 100 times greater than that in the general population and far greater than that for other types of malignant tumors in transplant recipients. It is suggested that the presence of the foreign organ transplant together with the immunosuppressive therapy was responsible for this remarkable increase in the incidence of lymphoma. Nevertheless, the benefits of renal transplantation with current methods still make it the treatment of choice for endstage renal disease."

(March 20, 1972,  
p. 1593, "Abstract")

12. False

"Lymphomas have been induced in mice by treatment both with azathioprine and also the closely related drug, mercaptopurine. On the other hand, no lymphomas have developed in patients treated with azathioprine alone or in conjunction with corticosteroids for diseases where no renal transplant was present. Also, George Hitchings, Ph.D, who has followed the development and clinical application of azathioprine from its inception knows of no lymphomas in patients who did

not receive transplants (written communication, Sept. 24, 1970).

"These observations suggest that the presence of the foreign organ transplant may play an important role in the genesis of lymphomas in transplant recipients, as Doak et al and Penn et al have suggested. Perhaps continued stimulation of lymphoid cells by the presence of the large mass of foreign tissue made these cells particularly likely to transform into malignant cells and the immunosuppressive agents prevented their elimination by blocking the recognition of tumor antigen. Experiments showing that the incidence of lymphomas was dramatically increased in some mouse strains with graft-vs-host disease support this concept. Also, antilymphocyte serum and antilymphocyte globulin might be more likely to induce lymphomas because they combine an immunosuppressive agent with the presence of a foreign protein, as Allison and Law have suggested."

(March 20, 1972,  
p. 1597, col. 1, para. 2)

13. True

"A drug-dependent woman who is pregnant should undergo withdrawal treatment prior to delivery. If there is insufficient time to accomplish withdrawal before delivery, the physician should maintain the woman on the required dose of methadone during confinement and delivery, and treat for withdrawal after delivery. The physician also should be alert for signs of drug dependence in the newborn, and should treat the infant for withdrawal."

(March 20, 1972,  
p. 1614, col. 3, para. 5)

14. False

"Applicants under 18 years

of age are usually not suitable candidates and should undergo especially careful history-taking. If their drug dependence is of short duration or minimal intensity, they should not be maintained on methadone, unless an alternative method was previously unsuccessful or unless a treatment modality other than methadone maintenance is not available (ie, detoxification and after-care, self-help groups)."

(March 20, 1972,  
p. 1618, col. 2, para. 2)

15. True

"Although some viruses, which may occur widely in food and water, are not considered to be pathogenic for man, it has been speculated that when they infect an unnatural host, such as man, they may play a role in carcinogenesis.

"Many human viruses multiply in the alimentary canal and are excreted in the feces of infected individuals. Their numbers are small when compared with the numbers of excreted bacteria since viruses do not multiply outside of living susceptible cells and decrease in numbers in the receiving waters. At the same time, the smallest amount of virus capable of infecting cells in culture is usually capable of producing at least a symptomless infection in man. Since minimal amounts of virus can produce infection, total removal of viruses from any water for human consumption would appear justified as a sound public health measure."

(March 20, 1972,  
p. 1628, col. 1, para. 2)

16. 1 = a, 2 = b

"Pregnant patients with homozygous sickle cell anemia, as well as patients with sickle cell hemoglobin C disease, have a high incidence (up to 25%) of spontaneous abortion, premature births, still births, and other fetal wastage. Maternal complications are also well recognized. One of the most serious complications in these patients is pulmonary infarction, which may result from primary occlusion of small vessels by masses of sickled erythrocytes, or by embolization of necrotic bone marrow, or by fat emboli. The incidence of pulmonary infarction seems to be higher in pregnant women with hemoglobin SC disease than in women with hemoglobin SS disease. The relationship between pulmonary infarction, cor pulmonale and sickle states has been reviewed by Moser and Shea.

"In blood smears from six patients who had sickle cell anemia with superimposed pulmonary emboli, 'blister cells,' irregularly contracted cells of thorn, helmet, and triangular shapes, and spherical, crenated, burr, and fragmented cells were reported by Barreres et al in 1968. These changes in erythrocyte structure are similar to the findings observed in patients with microangiopathic hemolytic anemia. Transitional cells between 'blister cells' and the helmet, triangular, and thorny erythrocytes were also present suggesting that 'blister cells' represent another morphologic feature of microangiopathy.

"The present report describes two pregnant women with sickle cell disease who had clinical suggestion of pulmonary embolism and whose peripheral blood smears showed significant numbers of erythrocytes having the typical appearance of 'blister cells'."

(March 27, 1972,  
p. 1729, col. 1, para. 3)

17. True

"The treatment of gonococcal meningitis consists of large doses of crystalline penicillin G. Ten to 40 million units a day were used in all three patients in this report for 14 to 23 days and proved adequate in controlling the infection. Relapse or significant neurological sequelae after adequate treatment have not been reported, which is true of patients in this series as well.

"In conclusion we would like to state that gonococcal meningitis be viewed with a high index of suspicion in a given patient with meningitis who presents with clinical symptomatology or past history of gonococcal infection. In such instances in addition to cerebrospinal fluid being cultured in appropriate media, specimens of urethral and vaginal smears should also be cultured in such media before initiation of therapy. This becomes more significant due to the increasing incidence of gonococcal infections at the present time."

(March 27, 1972,  
p. 1731, col. 3, para. 3)

18. True

"Liver scintiphotos were obtained of 11 patients in congestive heart failure in order

to measure the hepatic and splenic uptake as well as the liver size. When the patients were compensated, the parameters were repeated. During the failure state the scintiphoto revealed an increased spleen to liver uptake, perihepatic background activity, liver enlargement, and bone marrow uptake. These findings have been considered almost pathognomonic of advanced cirrhosis. When cardiac compensation was restored many of these abnormalities were no longer present. Thus, congestive heart failure can produce a liver scintiphoto which can simulate cirrhosis. Further the absence of presence of this pattern depends on the state of cardiac compensation."

(March 27, 1972,  
p. 1734, "Abstract")

19. True

"The data presented in this paper do not support the existence of a relationship between the utilization of a closed formulary and expenditure reductions. Hence, it would seem that more conclusive evidence is needed on the effects of formularies on drug expenditures, and health expenditures generally, before adoption of closed formularies is encouraged. It seems prudent, at the same time, to consider alternative means such as effective peer review to effect cost savings."

(March 27, 1972,  
p. 1744, col. 2, para. 3) ◀



# Deaths

## Ernest L. Eggers, M.D.

Dr. Ernest L. Eggers, Hammond, died June 10 at St. Margaret Hospital.

A graduate of the Chicago College of Medicine and Surgery, Dr. Eggers practiced medicine for 57 years and was a member of the 50-Year Club of the Indiana State Medical Association and of the Lake County Medical Society.

Before studying medicine, he served as superintendent of Putnam County schools.

## Bernard F. Kopanko, M.D.

Dr. Bernard F. Kopanko, 52, Hammond, died June 14 at St. Catherine Hospital, Hammond.

Dr. Kopanko had been a member of the St. Catherine staff for 20 years. He was a graduate of the Marquette University School of Medicine.

He was a member of the American College of Surgeons, American Medical Association and the Lake County Medical Society.

## Hector Quiambao, M.D.

Dr. Hector S. Quiambao, 58, Ridgeville, died at the Randolph County hospital June 18. He had served the community since November 1965.

A native of the Philippines, he was a graduate of St. Tomas University, Manila, and interned at San Juan de Dios Hospital. During World War II he served in the Far East, was captured during the fall of Bataan and survived the death march.

He came to the United States in 1956 and interned at St. Joseph Hospital, South Bend. He later interned in surgery at Mercy Hospital, Janesville, Wis., and spent three years in his specialty, gynecology and obstetrics, at St. Elizabeth Hospital, Lafayette.

He practiced in Attica for eighteen months, then returned to the Philippines

in 1963, moving to Ridgeville in 1965.

Dr. Quiambao was a member of the Randolph County Medical Society.

## Will C. Moore, M.D.

Dr. Will C. Moore, Muncie surgeon for more than 50 years, died June 17 at his home near Yorktown. He was 83.

Dr. Moore graduated from the Indiana University School of Medicine in 1914 and served internships at Dr. Eastman's Hospital, Indianapolis, Indianapolis City Hospital and Nevada Consolidated Hospital. He then studied surgery in Vienna for one year. Shortly after his return he went back to Europe for four years' service in an army evacuation hospital.

In 1964 Dr. Moore became a member of the ISMA 50-Year Club and estimated at that time that he had performed 75,000 operations. He retired in 1969 but remained active as a consultant until recently.

A member of the Delaware-Blackford County Medical Society, he had been a member of the American College of Surgeons since 1922.

## E. Rogers Smith, M.D.

Dr. E. Rogers Smith, 80, psychiatrist and professor emeritus of the Indiana University School of Medicine, died July 2 at his home in Indianapolis.

He received his doctor of medicine degree from the University of Michigan in 1918 and served in both World Wars. After three years in Arkansas, Dr. Smith moved to Indianapolis in 1922 and opened an office in the Hume Mansur Building, maintaining it for 50 years.

A member of the Indianapolis Motor Speedway medical staff from 1924 to 1951, he served as chief of the staff from 1938 to 1951, and was credited with pioneering a safety program, emphasizing belts, helmets and flame-resistant uniforms for drivers.

Dr. Smith was a life fellow of the American Psychiatry Association, was a member of the Marion County Medical Society and a Senior Member of the Indiana State Medical Association.

## Homer R. Swihart, M.D.

Dr. Homer R. Swihart, Elkhart general practitioner, died July 3 at his summer home in Chapleau, Ontario, Canada. He was 52.

A native of Elkhart, he began his practice there in 1947, following service in the Army Air Force in the Japanese and Korean theaters in World War II. He recently received a citation from the Elkhart Hospital Association for 25 years' service rendered the community.

Dr. Swihart was a graduate of the Indiana University School of Medicine and was a member of the Elkhart County Medical Society, the AMA and the Interstate Postgraduate Medical Service.

## George A. Thegze, M.D.

Dr. George A. Thegze, 62, East Chicago, died at St. Catherine Hospital June 4.

Dr. Thegze was graduated from the University of Budapest School of Medicine in 1935.

A member of the staff of St. Catherine Hospital, he was a member of the American College of Emergency Physicians, the Lake County Medical Society and the AMA.

## Arthur Vandever, M.D.

Dr. Arthur Vandever, 76, Sellersburg, died June 16 at Clark County Memorial Hospital.

A former member of the Clark County Medical Society, Dr. Vandever was a practicing Sellersburg physician from 1930 to 1967.

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"Scientific progress is continuously shifting the bottleneck in health care from the medical to the economic side. Already today we are capable of undertaking medically beneficial acts which exceed our economic resources. For future generations this discrepancy between what we can do medically and what we can afford economically is likely to become even more pronounced."—O. H. Nowotny.

# County, District News

## Fourth District

Dr. Guy Owsley, Hartford City, spoke on Peer Review at the annual meeting of the Fourth District Medical Society, which was held at Madison on May 17, and Dr. Raymond H. Murray, Indianapolis, spoke on Health Maintenance Organizations.

The after-dinner speaker was Mr. Rodney Ford, director of editorial services of WAVE-TV in Louisville, whose presentation was humorous in nature.

## Seventh District

Dr. Donald E. Stephens, Indianapolis, was named to the presidency of the Seventh District Medical Society at its June 14 meeting. Others placed in office for the coming year were: President-elect, Dr. Eric Clark, Plainfield; secretary-treasurer, Dr. M. O. Scamahorn, Pittsboro; trustee, Dr. Joseph F. Ferrara, Franklin; alternate trustees, Drs. Donald C. McCallum and John G. Pantzer, Indianapolis; and Blue Shield director, Dr. Stafford W. Pile, Jr., Indianapolis.

Dr. Otis Bowen, Bremen, spoke to the dinner group of 86 physicians and wives.

## Allen

Sixty-seven physicians were in attendance at the scientific meeting of the Fort Wayne-Allen County Medical Society on May 2 at the Chamber of Commerce. The speaker was Dr. Benjamin Felson, chairman of the department of radiology, University of Cincinnati College of Medicine. His topic was "Some Facets of Chest Roentgenology for the Clinician."

## Clark

Dr. David Jones, Charlestown, was elected delegate, and Dr. William L. Voskuhl, Charlestown, alternate ISMA delegate, at the June meeting of the Clark County Medical Society.

## Fayette-Franklin

At the meeting of the Fayette-Franklin County Medical Society held in Metamora on June 13 members elected officers and saw a film on the use of steroids.

Elected president was Dr. Perry Seal, Brookville, with Dr. Armando E. Angeles, Connersville, named vice president and Dr. Joseph L. Steinem, also of Connersville, secretary.

Dr. Noli C. Guinigundo, Brookville, will serve as the Franklin County delegate, while Dr. William F. Kerrigan, Connersville, will be the Fayette County delegate. Alternates will be Drs. Seal and A. M. Hudson, Connersville.

## Grant

Dr. Wendell W. Ayres, Marion, observed his 70th birthday June 27, which coincided with the regular monthly meeting of the Grant County Medical Society, and members presented him with a surprise birthday cake.

During the business meeting the group voted to contribute \$150 toward a sickle cell anemia testing program in Grant County and \$250 to the American Red Cross for flood disaster relief.

The scientific program was presented by Robert J. Rohn, M.D., of the Indiana University Medical Center, who discussed developments in the treatment of Hodgkin's Disease.

## Hamilton

Newly elected officers of the Hamilton County Medical Society are: Dr. R. Adrian Lanning, president; Dr. Eunice Carter, vice president; and Dr. Joe R. Lloyd, secretary. All are of Noblesville.

## Jay

Dr. George A. Donnally, Geneva, is the new president of the Jay County Medical Society; Dr. Amin T. Nasr, Portland, secretary; and Dr. James S. Fitzpatrick, Portland, will serve as delegate.

## LaPorte

The scientific portion of the program at the May meeting of the LaPorte County Medical Society was presented by Dr. James Greenwald, Hammond, who is director of the hemodialysis unit at St. Margaret Hospital. His subject was "Chronic Renal Failure."

On August 1 the LaPorte County Medical Society will move its offices to 1200 Michigan Ave.

## Tippecanoe

Fifty-three members were present on June 13 for the meeting of the Tippecanoe County Medical Society and heard a presentation by Dr. H. A. Rauchde, Indianapolis, on Surgery for Coronary Artery Disease.

Dr. Ira Cole, Lafayette, gave a report on the history of the Society.

## Whitley

Dr. Peter R. Petrich, ISMA president, addressed the June 6 meeting of the Whitley County Medical Society. Officers of the Twelfth District were invited to be special guests, as were wives of physicians attending.

## Wayne-Union

At a recent election the following were named to office in the Wayne-Union County Medical Society: President, Dr. Tom H. Ebbinghouse; president-elect, Dr. Frank Adney; secretary, Dr. John R. Dehner; treasurer, Dr. Charles Clarkson.

Drs. Loren Ake and John Ling were named to the executive committee, and Drs. Tom Shields and Glen Ward Lee were named delegates to the ISMA, with Drs. James Daggy and Joseph Zore alternate delegates.



# Association News

## EXECUTIVE COMMITTEE

Saturday, June 10, 1972

The Executive Committee convened at 2:00 p.m. on Saturday, June 10, 1972, at the headquarters building. Dr. Kerr, chairman, presided. Roll Call showed the following present: Donald M. Kerr, M.D., Chairman, Peter R. Petrich, M.D., Joe Dukes, M.D., Hugh K. Thatcher, Jr., M.D., Wilbert McIntosh, M.D., James H. Gosman, M.D., Lester H. Hoyt, M.D., Frank B. Ramsey, M.D., James A. Waggener.

MINUTES OF THE MEETING HELD APRIL 18 were approved upon motion of Dr. Petrich, seconded by Dr. Gosman.

MEMBERSHIP REPORT was accepted by consent.

### Headquarters Office:

A LETTER FROM DOROTHY AND BERNARD LEPORT praising the effort of the Association in settling a disability claim was read for the information of the Committee.

REPORT ON THE USE OF THE BUILDING during the first eight months of this fiscal year was given for the information of the Committee and it was recommended that this information be given to the Board of Trustees.

CONTRACT FOR THE INTRAVENIENT TRIP was approved by consent and signed.

EXCERPT FROM THE ARMY TIMES, announcing that the Department of Defense would take over the operation of CHAMPUS as of July 1, was read for the information of the Committee.

A PROPOSAL FOR REMODELING A PORTION OF THE OFFICE relocating some of the staff was discussed. A bid from Anning-Johnson was reviewed and the recommended changes were approved upon motion by Dr. Gosman, seconded by Dr. Petrich.

FIELD STAFF PROPOSAL. The secretary discussed the possibility of amalgamating the Regional Medical Program activities with the field services of the Indiana State Medical Association and the possibility of RMP supplying sufficient funds to employ two additional field men. This was approved and referred to the Board upon motion of Dr. Gosman, seconded by Dr. Petrich.

BYLAWS REGARDING DELEGATES. The secretary asked for clarification of Chapter IV, Section 2, of the Bylaws concerning a delegate to the State Convention, pointing out that in the case of a joint society, the Bylaws provide that each county is entitled to one delegate. However, the societies are not abiding by this provision of the Bylaws and are in some instances naming two delegates from the same county. By consent, this matter was referred to the Board of Trustees.

CERTIFICATES FOR OFFICERS. The secretary presented to the Committee certificates which were awarded to officers of the Wisconsin Medical Society and suggested it might be a good practice to follow in Indiana. Upon motion of Dr. Petrich, seconded by Dr. McIntosh, the secretary was authorized to procure similar certificates for awarding to officers of the Association.

DUES OF OTHER STATES. The secretary distributed to the Committee for their information a study made by the California Medical Association which listed dues of the various states for the year 1972.

A BILL FROM THE RAUP CABINET COMPANY for installation of an exhaust fan over the broiler was reviewed and, upon motion of Dr. McIntosh and seconded by Dr. Petrich, this was to be referred to Mrs. Stanley Cherrish.

PRINTING OF FOLDER. The secretary presented from the Commission on Public Information a pamphlet originating from the Illinois State Medical Society entitled "Medicare Misconceptions" with the recommendation that the Association publish a similar pamphlet to be made available to the membership at cost or below. By consent it was agreed that this proposal be submitted to the Board of Trustees.

CAR LEASING PROGRAM. A letter from the IMMKE Circle Leasing, Inc. of Columbus, Ohio, reporting on the number of cars which have been leased to Indiana members and giving us the names of those members, was read for the information of the Committee.

RULING ON MEMBERSHIP CLASSIFICATION. The secretary asked for a clarification of policy regarding the length of time we would carry individuals as military members and whether a man who might be in the military but serving in the public health service was considered military as far as exemption of dues was concerned. Upon motion of Dr. Petrich, seconded by Dr. McIntosh, these questions were referred to the Commission on Constitution and Bylaws.

BUILDING COMMITTEE. Upon motion of Dr. Petrich, seconded by Dr. Gosman, the Executive Committee took the action of sending information to the Building Committee, newly appointed, that they pursue the previous idea of planning for the expansion of the existing building.

### Treasurer's Report:

THE TREASURER'S REPORT was accepted by motion of Dr. Hoyt, seconded by Dr. McIntosh.

### Organization Matters:

R. M. P. ON FARM WORKERS. A letter from the Indiana Regional Medical Program concerning ISMA naming a representative to a group dealing with the health problems of farm workers was reviewed, and the secretary was requested to contact the districts of the state where migrant workers were used and to solicit candidates for this committee.

METHODIST HOSPITAL PEDIATRIC NURSES PROGRAM. Dr. Gosman again brought up the matter of the Association's writing a letter of endorsement to the Pediatric Nurses Training Program at the Methodist Hospital. Such a letter was authorized upon the motion of Dr. Gosman and taken by consent.

DOCTOR GROSZ — RECOMMENDATION ON METHADONE. A letter from Dr. Grosz requesting the Association to write a letter to the appropriate Federal officials seeking a delay in implementing regulations regarding the use of methadone was received. The request was approved by motion of Dr. Dukes, seconded by Dr. Gosman, and the secretary was instructed to write such a letter.

POLICY ON REQUEST UNDER P. L. 91-623. The secretary raised a question as to what position he should take in requests from county medical societies that the ISMA certify the need for physicians under Public Law 91-623. Upon motion of Dr. Gosman, seconded by Dr. Petrich, this matter was referred to the Board of Trustees.

VACANCIES ON AMA COUNCILS AND COMMITTEES. The secretary called attention to the matter which had been previously sent to members of the Executive Committee and the Trustees concerning vacancies appearing on the AMA Councils and Committees. Several recommendations were made for nominations of Indiana physicians for these vacancies. It was agreed that this



should be referred to the Board of Trustees.

**LETTER FROM WALTER C. BOR-NEMEIER, M.D.** A letter from Walter C. Bornemeier, M.D., immediate past president of the AMA, requesting the ISMA lend its name in support of a resolution (Declaration of Interdependence) to be presented to the AMA House of Delegates. This was reviewed and, upon motion of Dr. Dukes, it was taken by consent that the matter be referred to the Board of Trustees.

**PROPOSED LETTER TO NON-AMA MEMBERS** was reviewed, and the secretary was instructed to write, on an individual basis, letter to be jointly signed by the president and president-elect.

**REQUEST FOR A CONTRIBUTION FROM THE INDIANAPOLIS URBAN LEAGUE** was reviewed and, by consent, this was to be referred to the Marion County Medical Society, inasmuch as they are a local organization.

**LETTER FROM CHARLES A. BONSETT, M.D.—LILLY GRANT**—was read for the information of the Committee and the secretary was instructed to call a meeting of the Indiana Medical Education Foundation for the purpose of appropriating \$10,000 to match an equal amount from Eli Lilly and Company to be used in the restoration of the Old Pathology Building as a permanent museum on the Central State Hospital grounds.

**LETTER RECEIVED FROM THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS** offering the Association the opportunity to sponsor an accreditation institute was discussed and, upon motion of Dr. McIntosh, seconded by Dr. Dukes, the secretary was instructed to notify them that we are not interested at this time.

**CORRESPONDENCE BETWEEN THE SECRETARY AND THE DIRECTOR OF THE INDIANA COMPREHENSIVE HEALTH COUNCIL** was read for the information of the Committee, and action of the secretary was approved upon motion of Dr. Gosman, seconded by Dr. McIntosh. The secretary was also requested to obtain the names of physicians on this council.

**LETTER WAS RECEIVED FROM DAVID J. EDWARDS, M.D.,** State Board of Health, concerning the Association's cosponsoring the conference-workshop on "Medical Service and the Role of the Hospital in Rural Areas in Indiana." The cosponsoring was approved upon motion of Dr. Gosman,

seconded by Dr. Petrich, and the secretary was instructed to notify the Rural Health Committee concerning this proposal.

**RESOLUTION FROM CALIFORNIA MEDICAL ASSOCIATION.** A letter was received from the California Medical Association concerning a resolution which they adopted concerning the local Regional Medical Programs and, by consent, it was taken that the Indiana State Medical Association would support their position.

**A LETTER FROM SAMA, INDIANA CHAPTER,** addressed to President Petrich, expressing the appreciation to the Association in assisting with the financing of their delegates to their national convention, was read for the information of the Committee.

**THE OFFER OF A. H. ROBINS COMPANY, INC.** to give the Association \$200 for the purpose of scientific or educational use was referred to the Board of Trustees for their action.

**THE REQUEST OF THE COMMITTEE ON SPORTS AND MEDICINE** to conduct a survey of members to determine those who are interested in sports and medicine and those who are active with their local teams, was reviewed. Upon motion of Dr. Petrich, seconded by Dr. Gosman, this matter is to be referred to the Board of Trustees with the recommendation that it be approved.

**A REQUEST OF THE COMMISSION ON PUBLIC INFORMATION** to develop and computerize biographical information of the members of the Association, was reviewed and, by consent, referred to the Board of Trustees.

**A LETTER FROM THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS** concerning the proposed survey of six Indiana hospitals was read and, by consent, it was referred to the Board of Trustees.

**RESOLUTION FROM THE MARION COUNTY MEDICAL SOCIETY** calling upon the Indiana delegates in Congress to support an Enactment HR 12272 was read and, upon motion of Dr. Gosman, seconded by Dr. McIntosh, the Association will endorse their resolution and will also forward letters to the Indiana delegation requesting their support of the passage of this legislation.

## Convention Matters:

**DATES FOR THE STATE CONVENTION** listing October 20-25 for

1973, October 5-10 for 1974, October 11-16 for 1975, and October 9-14 for 1976, to be held at the Indiana Exposition Center, were approved by consent.

## Blue Cross-Blue Shield Reports:

**MINUTES.** The secretary read excerpts from the minutes of Blue Cross under date of March 23 and excerpts from Blue Shield minutes, April 20 and April 26, for the information of the Committee.

**LEGISLATIVE COUNCIL AUDIT.** The secretary reported on a matter which had come to his attention that a staff member of the Legislative Advisory Council had done a so-called audit of the Welfare Department, and of the Blue Cross-Blue Shield administration of Medicare and Medicaid, in which he understood there were several critical remarks made about the medical profession. He also understood that, while this report had as yet not been seen by the Legislative Council, there was a possibility that the *Indianapolis Star* would be publishing a portion of this report in the issue of Sunday, June 11. This was taken as a matter of information.

**A LETTER ADDRESSED TO ELI GOODMAN, M.D.,** trustee, from T. A. Neathamer, M.D., was read and, upon motion by Dr. Petrich and seconded by Dr. Dukes, this letter was referred to the Board of Trustees.

## Legal Matters:

**LEGAL OPINION ON USUAL AND CUSTOMARY.** The secretary presented a legal opinion from the attorney on the subject of usual and customary fees. Upon motion of Dr. Petrich, seconded by Dr. Gosman, it was taken as a matter of information.

**SECRETARY REPORTED ON THE LETTER FROM MITCHELL E. GOLDENBERG, M.D.,** of Munster, concerning the disclosure of records in Illinois and presenting the legal opinion which he had been requested to obtain concerning the Illinois system. He reported that the attorney said that this was not the system used in the state of Indiana and legal counsel advised that a doctor not release his original records to anyone. If there is a subpoena the doctor is urged to make a copy of the records and retain the originals in his own file.

**MISSOURI COURT DECISION ON**



**THE PHYSICIAN ASSISTANT.** A decision was made by the Missouri Supreme Court concerning the use of ancillary personnel, which may have the effect of declaring all doctors in violation of the law in the use of medical assistants and other types of ancillary personnel.

### The Journal:

**CARTER-SHIELDS, INC.** requested space in **THE JOURNAL**. This was approved upon motion of Dr. McIntosh and seconded by Dr. Gosman.

**NURSE CARE INTERNATIONAL, INC.** requested space which was approved upon motion of Dr. McIntosh, seconded by Dr. Petrich.

**PRINTING OF THE JOURNAL.** The secretary reported on the action of the Board and the Executive Committee concerning the printing of **THE JOURNAL** and he had been asked by Dr. Shields to delay the transfer, which had been done. The secretary requested guidance as to continued use of the present printer or whether to transfer to the other printer who had been previously selected. Upon motion of Dr. Dukes it was taken by consent and again referred to the Board of Trustees for their decision.

### Legislation:

**ACTIVITIES—LEGISLATIVE ADVISORY COMMITTEE** was reported on by the secretary and concerning a request he had received from Representative Bales for the Association to express an opinion concerning Indiana's adopting a law similar to that of Minnesota dealing with the physician assistant and ancillary personnel. Upon motion by

Dr. Petrich, seconded by McIntosh, it was decided that Dr. Gosman attend this meeting and express his opinion concerning such legislation.

**ESTABLISHMENT OF HMOs.** The secretary reported that he had a call from the Insurance Commissioner requesting that the Association name a committee representative to study legislation which might be proposed permitting the establishment of HMO-type groups in the state of Indiana. Upon motion of Dr. Petrich, seconded by Dr. Gosman, the names of Drs. Hawkins, McIntosh, Dukes and Petrich are to be submitted.

### Candidates for AMA Office:

**THE SECRETARY REVIEWED** for the information of the committee letters from Georgia, Tennessee, Oregon and Ohio concerning candidates who were running for the various AMA offices.

### New Business:

**RESOLUTION PROPOSED FOR INTRODUCTION AT AMA MEETING.** The secretary presented a resolution that Dr. Wood had requested the Association consider and which was to be introduced at the San Francisco meeting and, by consent, this was referred to the Board of Trustees.

**PAYMENT OF PHYSICIANS' FEES.** The secretary reported that the Commission on Medical Economics and Insurance had discussed the General Motors contract and payment of physicians' fees by Blue Shield under this contract. It is the impression that Blue Shield arbitrarily determines the usual and customary fee and offers to defend their position in case the doctor at-

tempts to collect an additional amount. Inasmuch as a contract says the doctor cannot collect additional fees unless he has a prior agreement with the patient, it was suggested that a contract form might be useful for the physician to prove he had such prior discussion. A sample form was presented which was referred to the Board of Trustees by consent.

**APPROPRIATIONS — CONGRESS.** Dr. Petrich read a letter which he had received from Congressman Roush concerning various appropriations currently before the Congress for approval.

**INSURANCE PACKAGE PROGRAM.** President Petrich also discussed the insurance package program utilized by the Illinois State Medical Society and, upon motion of Dr. Gosman, seconded by Dr. McIntosh, the Committee approved the president's inviting a representative of the company to discuss this program with the Committee.

### Future Meetings:

**HEALTH MANPOWER INSTITUTE.** By consent, Dr. McIntosh was authorized to attend this Institute to be held in Indianapolis on June 28.

**INTERNATIONAL SYMPOSIUM ON EMERGENCY MEDICAL SERVICES** in Honolulu July 31-August 4. No representative to be sent.

**UNI-MED SERVICES, INC.—Seminars Foundations—to be held in Denver in August. No representative will be sent.**

### Date of Next Meeting:

There being no further business, the committee adjourned to meet at 5:00 p.m. on Saturday, August 5, 1972.

## About Our Cover

Reproduced on our cover is a photograph of insulin crystals which was made available to **THE JOURNAL** through the courtesy of Mr. E. B. Herr, Jr., Eli Lilly and Company.

# COMMERCIAL ANNOUNCEMENTS

FOR SALE: Officially, Attested, Advanced Register Angus bulls, also, frozen semen from proven sires. Write today for prices and production data.

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Telephones: 301/827-7160  
301/827-7166

## ORTHOPAEDIC SURGEON WANTED

TO JOIN three man orthopaedic surgeons clinic in progressive, well industrialized, attractive, midwest city.

Call collect or write details to: Orthopaedic Clinic, 402 South Berkley Road, Kokomo, Indiana 46901. Telephone: (317) 457-4401.

WANTED — well trained internist or general practitioner who is interested in improving and expanding the physical exam department of an industrial clinic in Indianapolis. The physical exams include routine pre-employment, executive and special examinations. Reply Box 371.

NEW ULTRA-MODERN medical building has 3 suites available for immediate occupancy. Desirable especially for ophthalmologist, radiologist, E.N.T., O.B., Gyn., Pediatrician, family practice. Pharmacy next door. All utilities included except phone. Write J. A. Torrella, M.D., Torella Medical Building, 5324 West 16th Street, Speedway City, Indiana 46224, or phone collect, 317-244-5942 or 317-244-4578.

## 15 PHYSICIANS NEEDED

ALL SPECIALTIES AND GPs, TO \$50,000 PER YEAR. Normal hours, excellent fringe benefits, ideal family living conditions, locations in Indiana. Send curriculum vitae or call: John W. Brill, area code 317, 547-9595, Brill Personnel, Inc., 4000 Meadows Drive, Suite 102, Indianapolis, Ind. 46205.

WANTED—Full time GP with prospects of membership in corporation in a growing town in northwest Indiana. If interested please submit resume. Salary open. South County Medical Corporation, 13963 Morse St., Cedar Lake, Ind. 46303, 219-374-5431, M. J. Whelan, Administrator.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with

military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220.

NOW AVAILABLE in new, modern Medical Building, 1400 sq. ft. of space suitable for orthopedic clinic. X-ray facilities also available. All utilities included except electricity and phone. Write J. A. Torella, M.D., Torella Medical Building, 5324 West 16th Street, Speedway City, Indiana 46224, or phone collect, 317-244-5942 or 317-244-4578.

WANTED — Physician interested in industrial medicine for rapidly growing industrial clinic in Indianapolis. Reply Box 372.

PART OR FULL TIME physician wanted for Indiana Rehabilitation Services. Please contact Mr. Walter J. Penrod, phone 317-633-7946, or write same at 17 W. Market St., 1028 Illinois Bldg., Indianapolis 46204.

WANTED TWO (2) FAMILY PHYSICIANS — to join group of three (3) well established family physicians who recently moved into their ultra modern clinic building next to the new 431 bed hospital in Richmond, Indiana. Reply Box 377, THE JOURNAL.

WANTED: Assistant M.D. on two-doctor staff, Culver Military Academy and Culver Academy for Girls, Culver, Indiana, starting September 1972 or at reasonable date beyond. Pleasant well-regulated position; 50-bed hospital with out-patient department. Attend 800+ students, faculty, staff and employees. 1500 acre campus on Lake Maxinkuckee. All sports including campus golf course. Much reduced rates for children or grandchildren to attend Academies (high school level). Salary open to discussion. Contact Lt. General John W. Carpenter, III USAF (Ret.) 219-842-3311

### PHYSICIANS NEEDED:

Orthopedic and General Surgeons, Urologists, Internists, OB-Gynecologists, and General Practitioners to establish independent practice in Petoskey, Michigan — The Midwest's Skiing Mecca and world famous summer resort community. Local college, excellent schools, seasonal sports, summer and winter concerts. A great selection of restaurants, theatre, hunting, fishing, golfing, sailing, unique and unusual summer shops, and frequent airline service make this an unrivaled living area.

New acute care, general hospital will provide one year's rental on adjacent luxurious office suites, moving stipend, and negotiate other financial arrangements.

Contact — Milton D. Rassmussen, Administrator  
or Wendell C. Trent, Asst. Administrator  
Area 616-347-3985.

FOR SALE—Office equipment, drugs, practice, and building, 10 years old. Has four examining rooms, x-ray room and emergency room. Established 12 years. Desire to take full time salaried job. C. L. Entner, M.D., 226 S. Meridian St., Dunkirk, IN 47336.

Continued

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00

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Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.



3 EMERGENCY ROOM PHYSICIANS wanted to staff new E. R. facilities of 200 Bed Hospital. 50 man multispecialty Clinic physically adjacent provides immediate consultation and support. No pediatric responsibility. Michigan Resort City on Lake Michigan. Salary negotiable. Many fringe benefits.

Reply to: John Rasmussen, Administrator

Burns Clinic Medical Center, P.C.

Petoskey, Michigan 49770

OFFICE SPACE available for lease in the new Jeffersville Medical Arts Building. Excellent location—across from Clark County Memorial Hospital, Jeffersonville, Ind. For details, contact Mr. James F. Snyder, 504 South 6th St., Louisville, Ky. 40203, or telephone 502-585-4155.

FOR SALE, lease or rent: general practice, fully equipped busy office. Financial records available. Located 10 minutes from new St. Vincent's Hospital, Indpls.; 15 minutes from Witham Hospital, Lebanon, Ind. Write to L. S. Bailey, M. D., 95 E. Oak, Zionsville, Ind. 46077.

INTERNISTS and family physicians badly needed in Atlanta suburb near third busiest airport in world. New offices available adjacent to new 385-bed South Fulton community hospital.

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ASSOCIATE IN FAMILY MEDICINE, TOLEDO. Young, dynamic family practice. Modern, well-equipped office. Must have boards or be working on same. For right physician "offer you can't refuse." I need help but am willing to wait for right person. Reply Box 376, THE JOURNAL, ISMA, 3935 N. Meridian St., Indianapolis 46208.

FOR LEASE OR SALE—Med-Dental Bldg., approx 3,000 sq. ft; north of Fort Wayne. Newly decar., fully carpeted, air cond., good parking, same equipment available. Also need locum tenens for August 1972. References required. R. L. Hillery, 5110 N. Clinton, Univ. Pk Cl., Fort Wayne, Ind. (219) 483-9591.

#### ASSOCIATE

#### MEDICAL DIRECTOR

Inland Steel Co., Indiana Harbor Works, one of Chicagoland's largest manufacturing complexes, is seeking an Associate Medical Director.

Our Medical Department is a fully staffed complex including an X-Ray, Laboratory, and an occupational hygiene division.

There is a full range of medical activities including traumatic, pre-placement and consultative services in a plant whose population exceeds 20,000. Salary is negotiable with an outstanding no-cost benefit package included.

Reply to:

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The



# JOURNAL

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CONVENTION  
ISSUE

SMA ANNUAL MEETING • October 14-18, 1972 • INDIANAPOLIS



The negative power of clinically significant anxiety  
in angina pectoris...



This man feels he is living  
on borrowed time.



During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,\* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)*

*Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.*

The positive power of  
adjunctive  
**Librium®**  
(chlordiazepoxide HCl)  
10-mg, 25-mg capsules  
up to 100 mg daily  
for moderate  
to severe anxiety  
accompanying angina pectoris

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido — all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

\*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.



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# FOR BETTER FOR WORSE FOR RICHER FOR POORER IN SICKNESS IN HEALTH

This is a vow we've taken with almost two million members. For at Blue Cross and Blue Shield our success is measured not in earnings but in the health care benefits we provide our members. □ And the protection is always there. You won't lose your coverage because you're in poor health or because of the number of times you've been in the hospital. □ Move to a new job, and we can transfer your Blue Cross and Blue Shield from state to state. □ Retire from a job where you had a group plan, and you're still eligible for our individual plans, including Medicare Supplement Plus. □ Get sick or have an accident outside Indiana, and our membership card will get you into any of 6,500 hospitals. □ One out of every three Hoosiers is a member of Indiana Blue Cross and Blue Shield. That's a big responsibility. And we try to live up to your trust.

**something  
to have**

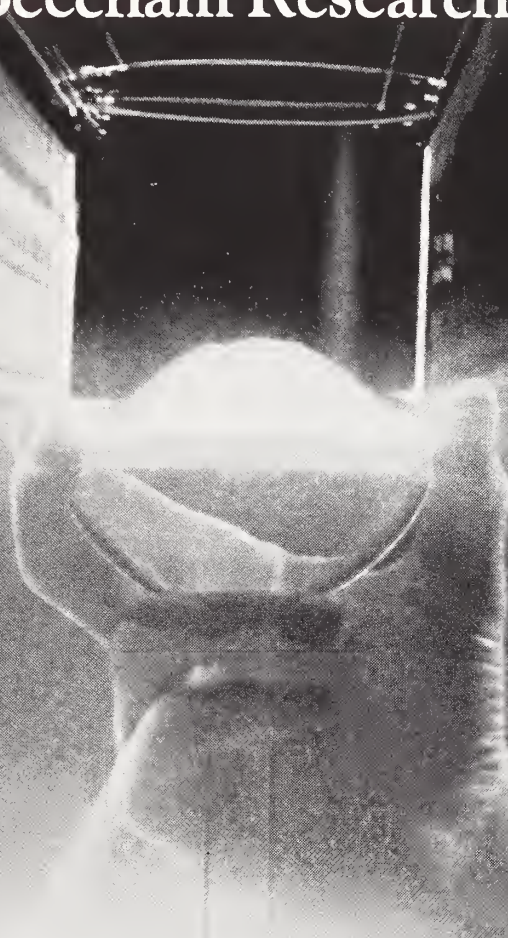
**and hold onto**





# May 1957

The age of semi-synthetic penicillins  
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The crucial experiment: conversion of 6-aminopenicillanic acid (6-APA) into benzylpenicillin by treatment with phenylacetyl chloride. We've come a long way since 1957. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today.

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**Totacillin**<sup>®</sup> ampicillin trihydrate

**Pyopen**<sup>®</sup> disodium carbenicillin

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**Beecham-Massengill  
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Div. of Beecham Inc., Bristol, Tennessee 37620

☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin. ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin. ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.



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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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Indexed in Hospital Literature Index.

About Our Cover

on page 1031

# Why send him to the islets of Langerhans?



Since sulfonylureas promote the release of insulin which is lipogenic and helps transport glucose into adipose tissue...

And since many overweight patients already have normal or high levels of endogenous insulin, why not consider DBI-TD?

It lowers blood sugar without stimulating

insulin secretion from the pancreas. And this may be important to the dieting diabetic.

In adult-onset, nonketotic diabetics uncontrolled by diet alone...

**DBI-TD<sup>®</sup> Geigy**  
**phenformin HCl**

**lowers blood sugar without raising blood insulin.**

#### **DBI<sup>®</sup> phenformin HCl**

**Tablets of 25 mg.**

**DBI-TD<sup>®</sup> phenformin HCl**

**Timed-Disintegration**

**Capsules of 50 and 100 mg.**

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:*

This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state.

**Do not give insulin without first checking blood and urine sugar.**

2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-D (6/72)

*For complete details, including dosage, please see full prescribing information.*

GEIGY Pharmaceuticals  
Division of  
CIBA-GEIGY Corporation  
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# a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® Tablets, brand of pentazocine (as hydrochloride), can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. Patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with meperidine or codeine. And that, in the long run, can mean a better outlook for your chronic-pain patient.

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- **Not subject to narcotic controls:** convenient to prescribe — day or night — even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, light-headedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin®**  
brand of  
**pentazocine**

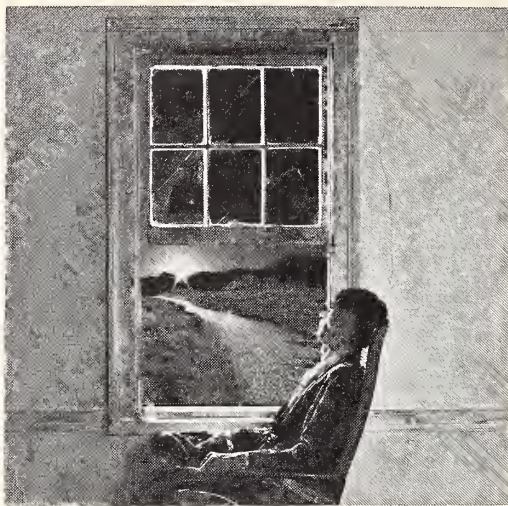
(as hydrochloride)

the long-range analgesic



# a new outlook in chronic pain

of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it. **Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

**Usage in Pregnancy.** Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

**Drug Dependence.** There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

**Acute CNS Manifestations.** Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

**Usage in Children.** Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Ambulatory Patients.** Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions: Certain Respiratory Conditions.** Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

**Impaired Renal or Hepatic Function.** Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

**Myocardial Infarction.** As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

**Biliary Surgery.** Until further experience is gained with the effects

of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract. **Patients Receiving Narcotics.** Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

**CNS Effect.** Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. **CNS effects:** dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. **Autonomic:** sweating; infrequently flushing; and rarely chills. **Allergic:** infrequently rash; and rarely urticaria, edema of the face. **Cardiovascular:** infrequently decrease in blood pressure, tachycardia. **Other:** rarely respiratory depression, urinary retention.

**Dosage and Administration: Adults.** The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

**Children Under 12 Years of Age.** Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Duration of Therapy.** Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage: Manifestations.** Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

**Treatment.** Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

**Winthrop** Winthrop Laboratories, New York, N. Y. 10016 (1583)

50 mg. Tablets

**Talwin®**  
brand of  
**pentazocine** (as hydrochloride)

the long-range analgesic





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

**THE DEMOCRATIC** National Convention shouted approval of "a system of universal national health insurance" financed by federal funds and administered by the federal government.

**THE PLATFORM PLANK** adopted by the convention at Miami Beach declares that a national health plan should cover all Americans "with a comprehensive set of benefits including preventive medicine, mental and emotional disorders, and complete protection against catastrophic costs, and in which the rule of free choice for both provider and consumer is protected. The program should be federally financed and federally administered."

**THERE WAS** little debate on the plank and little attention paid to it at the hectic convention where most interest was focused on the abortive stop-McGovern fight and on foreign affairs, taxes, welfare and other domestic concerns of the party platform that split the delegates.

**CONSPICUOUSLY MISSING** from the health plank were any detailed recommendations on how the national health insurance program should be funded, how the government would operate it, or the cost, leaving Democratic presidential candidate George McGovern free to come up with his own program if he desires.

**THE PLATFORM** on health declares that "good health is the least this society should promise its citizens. The state of health services in this country indicates the failure of government to respond to this fundamental need. Costs skyrocket while the availability of services for all but the rich steadily decline."

**THE PLANK** states that the "next democratic administration" should:

- incorporate in the national health insurance system incentives and controls to curb inflation in health care costs and to assure efficient delivery of all services;

- Continue to evaluate health maintenance organizations;

- Set up incentives to bring health service personnel back to inner-cities and rural areas;

- Continue to expand community health centers and availability of early screening diagnosis and treatment;

- Provide federal funds to train added health manpower including doctors, nurses, technicians and para-medical workers;

- Secure greater consumer participation and control over health care institutions;

- Expand federal support for medical research including research in heart disease, hypertension, stroke, cancer, sickle cell anemia, occupational and childhood diseases which threaten millions;

- Eventual replacement of all federal programs of health care by a comprehensive national health insurance system;

- Take legal and other action "to curb soaring prices for vital drugs using

Continued



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 14-18, 1972—Indianapolis

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2—Joe Dukes, Dugger (Chairman)	Oct. 1972
3—Eli Goodman, Charlestown	Oct. 1973
4—Howard C. Jackson, Madison	Oct. 1974
5—Wilbert McIntosh, Riley	Oct. 1972
6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
7—Dwight W. Schuster, Indianapolis	Oct. 1972
8—Richard Ingram, Montpelier	Oct. 1972
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—Lowell Hillis, Logansport	Oct. 1972
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

## ALTERNATES

District	Term Expires
1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—Cleon M. Schauwecker, Greencastle	1973
6—Glen Ward Lee, Richmond	1975
7—Joseph F. Ferrara, Frankin	1972
7—Joseph C. Kerlin Danville	1972
8—Jack L. Alexander, Muncie	1973
9—Max N. Hoffman, Covington	1974
10—Thomas C. Tyrrell, Hammond	1972
11—James A. Harshman, Kokomo	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1973

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Eugene F. Senseny Fort Wayne	Eugene S. Rifner Van Buren
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1973:

Delegates	Alternates
Jack E. Shields Brownstown	Patrick J. V. Corcoran Evansville
Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

## 1971-72 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Bernard B. Rosenblatt, Evansville	John Winebrenner, Evansville	May 10, 1973, Evansville
2.		J. S. Brown, Carlisle	Bloomington
3.	Claude J. Meyer, Sellersburg	Charles X. McCalla, Paoli	September 1973, Clarksville
4.	Kenneth Schneider, Columbus	C. David Ryan, Columbus	Columbus
5.	James C. Lett, Greencastle	J. Franklin Swaim, Rockville	May 23, 1973, Greencastle
6.	John Moenning, Greenfield	Davis W. Ellis, Jr., Rushville	May 2, 1973, Rushville
7.	Donald E. Stephens, Indianapolis	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	June 6, 1973, Muncie
9.	Don W. Boyer, Lebanon	Clarence G. Kern, Lebanon	June 14, 1973, Lafayette
10.	Lambro Dimitroff, Hammond	Mario D. Mansueto, Munster	May 30, 1973, Hebron
11.	John Elleman, Kokomo	Fred Poehler, La Fontaine	Sept. 20, 1972, Kokomo
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	September 14, 1972, Fort Wayne
13.	Frank McGue, Michigan City	David L. Spalding, Mishawaka	Sept. 13, 1972, Michigan City



anti-trust laws as applicable and amending patent laws to end price-raising abuses and require generic-name labeling of equal-effective drugs;

—Expand federal research and support for drug abuse treatment and education, especially development of non-addictive treatment methods.”

SEN. GEORGE McGovern’s stand on health is not clear at this time. The candidate did not stress health or any specific health legislation in his pre-convention bids for popular votes. However, he is expected shortly to set down his ideas on a national health program, a plan that likely will incorporate much of the Kennedy-Griffiths philosophy.

IN THIS UNUSUAL election year which has turned the Democrats inside out, the McGovern brain trust might decide to promote health once the campaign gets going. It could be one of the battleground issues. Right now, though, the Nixon administration appears to have “de-fused” health by forcing the debate on the question of degree, not on whether there should be a national health program. Furthermore, Administration spokesmen can point to the fact that the democratically-controlled congress did not act on the Administration’s health program or any other for two years.

#### NEW HEW POLICY MEETS AHA OBJECTIONS

THE HEW DEPARTMENT has said hospitals funded under the Hill-Burton Act will be reviewed on a case-to-case basis to determine whether a “reasonable volume” of free care is furnished to persons unable to pay.

THIS INTERIM regulation will enable hospitals already providing a large amount of free care to submit a financial report to that effect and be automatically in compliance. It also provides “presumptive compliance” levels of free care, lower than first recommended in April, which can be met in any one of three ways an institution chooses. In addition, it sets guidelines for individualized determination for hospitals which are unable to meet the “presumptive compliance” levels.

IN GENERAL, the new policy met objections of the American Hospital Association that the original proposals could put many hospitals out of business.

HEW SECRETARY Elliot Richardson said the regulation, modified as recommended to him by the Federal Hospital Council, is being issued now in interim form so that some regulation be immediately in effect, in view of pending court cases seeking to compel him to act promptly.

VERNON E. WILSON, M.D., Administrator of the Health Services and Mental Health Administration, which directs the Hill-Burton program, said:

“MUCH misunderstanding arose over the earlier version of this interim regulation published for comment back in April. Many people felt that the ‘presumptive compliance’ guidelines constituted standards to which hospitals would be held. It is important to understand that any institution which falls below the ‘presumptive compliance’ guidelines will have an individualized determination of what constitutes a reasonable volume of free care.”

#### NIH TO CONDUCT MAJOR STUDY OF ACUPUNCTURE

THE NATIONAL Institutes of Health has announced it will conduct major study of acupuncture, the ancient Chinese medical practice of curing illness and relieving pain by piercing the skin with needles.

HOWARD J. JENERICK, special assistant to the director of the National Institute of General Medical

# COUNTY MEDICAL SOCIETY DIRECTORY

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Sullivan	John T. Burns, Lafayette	J. C. Bacala, 69 E. Wardell St., Scottsburg 47170
Tippecanoe	Jean V. Carter, Tipton	Harry Gordon, Ten Northridge Park, P. O. Box 70, Shelbyville 46176
Tipton	William H. Getty, Evansville	John C. Glackman, Jr., Rockport
Vanderburgh	Werner L. Loewenstein, Terre Haute	Robert J. Goode, 201 S. Heaton St., Knox 46534
Vigo	Michael Silvers, North Manchester	Claude E. Davis, 1109 W. Maumee, Angola 46703
Wabash	Peter B. Hoover, Boonville	J. S. Brown, Carlisle
Warrick	T. K. Tower, Campbellsburg	Caroline E. Hass, 316 N. Salisbury St., West Lafayette 47906
Washington	Tom H. Ebbinghouse, Richmond	Boyd A. Burkhardt, 202 S. West St., Tipton 46072
Wayne-Union	Louis F. Bradley, Bluffton	Mrs. Carole Rust, Exec. Dir., 421 N. Main St., Evansville 47711
Wells	Gerald R. Bougher, Monticello	J. Lewis Stoelting, 1724 N. 7th St., Terre Haute
White	Warren Niccum, Columbia City	William L. Purcell, Exec. Secy., P. O. Box 986, Terre Haute
Whitley		J. Dean Giffard, c/o Wabash County Hospital, Wabash 46992
		Robert C. Colvin, Newburgh
		F. T. Castueras, 906 W. Mulberry, Salem 47167
		John Dehner, Reid Memorial Hospital, Richmond
		Russell E. Graf, 1110 Highland Park Circle, Bluffton 46714
		W. Martin Dickerson, 1114 O'Connor Blvd., Monticello 47960
		V. P. Huffman, 201 N. State St., South Whitley 46787



Sciences, said the study would involve use of acupuncture as an anesthetic and alleviation of pain from neuralgia, nerve injuries and cancer.

HE PREDICTED the study, to cost "hundreds of thousands" of dollars, would lead to acupuncture treatment of American patients within a year.

"ACUPUNCTURE is an important thing that has to be looked into," Jenerick said. "We are now committed to starting a significant investigation of it. The question is whether you want to shoot for the moon or send somebody to the corner book store for a book about it. This will be somewhere in between those extremes."

THE ANNOUNCEMENT was made in a statement by Dr. Robert Q. Marston, NIH Director, who said the investigation was recommended by a committee of experts in anesthesiology, neurology, neurophysiology and psychology who met July 17-18 at NIH. Committee chairman was Dr. John J. Donican, a pain authority at the University of Washington's School of Medicine in Seattle.

"AFTER considering the many suggested uses of acupuncture, the Committee recommended that the most valuable first approach in the United States would be studies on the method's use for surgical anesthesia and for the alleviation of certain chronic pain syndromes," Marston said.

AMONG uses considered by the Committee but rejected for immediate exploration were acupuncture treatment for arthritis, toothache, low back pain, rheumatism and insomnia, Jenerick said.

#### BATTLE OVER FUNDING OF FEDERAL HEALTH PROGRAMS FORESEEN

AN ELECTION YEAR battle between a democratic congress and President Nixon is in prospect over bill appropriating funds for federal health programs. Nixon feels budget-busting HEW money bill which soared \$2 billion above what he recommended and other pending appropriation measures will send the federal budget for this fiscal year out of sight. White House aides say Congress already has topped the budget by more than \$6 billion.

NIXON IS considering either a special message to Congress, or a national television address, or both, outlining the perils of higher federal outlays. The maneuvering for political advantage that will mark the remainder of this session of Congress promises the fascination and intricacies of a championship chess match. Nixon is prepared to pound home the theme that fat federal budgets lead to inflation and higher federal taxes. Democrats are geared to holler that the Administration wants to chop vital and popular federal programs.

"THERE SEEMS to be a cynical strategy on the part of some democratic leaders to deliberately send to the President proposals with good objectives but proposals that substantially exceed his budget requests," declared William Timmons, White House Assistant for Congressional Relations. President Nixon was quoted by Secretary of the Treasury George Shultz as saying that "the ball game on the control of inflation is fought out fundamentally in terms of monetary and fiscal policy . . . We feel that we are at the point where any time you have a vote for extra spending going beyond the President's budget, you have a vote for higher prices or higher taxes."

#### BILL FOR EXTRA PAY FOR MILITARY PHYSICIANS STANDS EXCELLENT CHANCE OF PASSAGE

THE FATE of the physicians' draft next year rests with Congress and the extra pay bill

Continued

# ISMA Committees and Commissions for 1971-1972

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for military physicians . . . a measure now before the House Armed Services Committee.

ASSISTANT Secretary of Defense for Health and Environment, Richard Wilbur, M.D., who helped fashion the new program, is keeping his fingers crossed that the lawmakers will okay the bill this session. Without it he says, the draft undoubtedly will have to be extended for young physicians.

LITTLE CONTROVERSY has cropped up over the legislation and barring some unexpected obstacle, it stands an excellent chance of whisking through Congress before adjournment this year.

DESIGNED TO "facilitate the establishment of an all voluntary army and to maintain sufficient numbers of career officers in critical areas," the pay bill authorizes yearly bonuses of up to \$17,000 for qualified physicians "in addition to any other pay or allowances to which he was entitled."

THIS WOULD BE in addition to the \$100 a month extra pay for the first two years of service and \$350 a month thereafter.

#### AID FOR STATE, LOCAL POLICE AND PROSECUTORS IN DRUG VIOLATIONS

THE PERSISTENT spillover of legal drugs to the black market has spurred the federal government to inaugurate a program of training state and local police and prosecutors in the intricacies of running down the malefactors.

A PILOT PROGRAM being started for Texas, Michigan and Mississippi will receive \$333,000 to finance the training which will be conducted in Washington, D.C.

AN OFFICIAL of the Bureau of Narcotics and Dangerous Drugs has said that despite the existence of federal legislation in the field and the enactment by 35 states of model state-controlled substances acts, the illegal diversion of drugs remain a major problem.

THE BNDD exercises its supervision at the level of the manufacturer and distributor, the states are responsible for policing at the retail level—retail and hospital pharmacies, and physicians' offices.

ACCORDING to a BNDD official, many local police are not equipped or trained to carry out the type of detective work required to ferret out people selling legitimate drugs on the black market. In addition, he noted, prosecutors are not familiar with this area and unsure of how to handle the cases that are brought.

SPECIALIZED TRAINING in such fields as bookkeeping is needed because often the evidence, as in tax cases, depends on careful checking of the mandatory records that must be kept by all who dispense drugs that are subject to abuse, the BNDD aide said.

HE ADDED that even when police are alerted to the apparent criminal dealings of a local pharmacy, for example, they often find themselves in a position where they do not know how to accumulate the required evidence of wrongdoing.

#### NURSING HOME FUNDS WITHHELD FOR SUBSTANDARD CONDITIONS

FEDERAL FUNDS have been withheld from 579 nursing homes for failure to meet minimum standards of health and safety as ordered by President Nixon last August.

HEW SECRETARY John Veneman said 327 nursing homes—222 of them in New York state—lost their certification and another 252 homes withdrew from the program because they were unable or unwilling to meet the standards.

OF THE approximately 7,000 homes receiving federal nursing home aid, 1,469 received full certification and 4,766 were certified for six months to give them time to correct deficiencies not affecting health and safety. An additional 244 are still in the certification process.

VENEMAN'S REPORT covered only nursing homes which received federal aid under the medicaid program. It did not affect the approximately 16,000 homes for the elderly not receiving such assistance.

VENEMAN SAID the year-long re-certification process indicated "the majority of nursing homes are providing quality care in safe and helpful surroundings."

SOME RELAXATION of tight fee hike controls on physicians may be in the offing. Health Services Industry Committee is considering changes in basic regulations covering institutional and non-institutional providers. There is a possibility that present 2.5 percent limit may be upped to some degree on allowable fee increases for physicians and dentists, lowest rate permitted for any profession except those with more than 60 employees. Committee members believe controls have worked well to date in the health field, pointing to sharp slash in cost rise since control imposition.

#### ILLEGAL TRAFFIC IN METHADONE CURB EXPECTED

THE ADMINISTRATION soon will recommend legislation to halt illegal traffic in methadone as a substitute for heroin.

JOHN INGERSOLL, Director of the Bureau of Narcotics and Dangerous Drugs, told the National Commission on Marijuana and Drug Abuse: "The increase in the last several years is so dramatic as to indicate that our present legal controls are inadequate."

INGERSOLL said that in New York City 92% of a group of heroin addicts reported they had been offered illegal methadone by pushers and 13% said they had sold it themselves.

HE SAID a similar study in Miami showed that 40% of the applicants to a legitimate methadone maintenance center already were using the drug illegally.

IN ADVISING the panel that the Administration soon would send Congress legislation, Ingersoll commented:

"IN SOME programs patients are actually permitted to handle and administer narcotic medication with the result that much of the drug has been pilfered for sale in the illicit traffic."

#### VACCINE MANUFACTURE HALTED RATHER THAN COMPLY WITH FDA REQUIREMENTS

TWO MANUFACTURERS have stopped producing nine bacterial vaccines, rather than attempt to meet the Food and Drug Administration's new requirements for "substantial evidence" of effectiveness.

THE NINE include several vaccines for upper respiratory infections, a staphylococcus vaccine, and a diagnostic agent for detecting brucellosis infection.

FIVE of the vaccines were produced by Merck & Dohme, a division of Merck & Co.; four were made by Merrill-National Laboratories, a division of Richardson-Merrell, Inc. The firms voluntarily turned in their product licenses, which were then cancelled by FDA.

BOTH COMPANIES said the vaccines were old, low-volume products, and sales would not justify the testing required by the new efficacy regulations.

ALL NINE products are among 32 licensed bacterial vaccines for which no standards of potency were ever established.

THE MERCK products include vacagen tablets, brucellen antigen, staphylo-strepto-serobacterin vaccine, catarrhalis serobactin vaccine, and sensitized bacterial vaccine-H influenzae. Merrill's products include catarrhalis serobactin vaccine, strepto-staphylo-vatox, respiratory vatox, and staphylococcus toxoid-vaccine vatox. ◀



*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

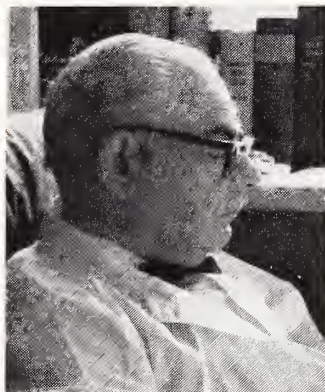
**No, it would not be useful.**

# Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. As I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the "drug of choice" in these areas of medical practice.



# Maker of Medicine

Kenneth G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Eli Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, and then it will be based on his experience with this drug and his knowledge of the individual patient who is seeking treatment.

If an evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a great disservice to medicine and thus to the patient and the consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at this time the new drug could be labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. After, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

What is your opinion, doctor?

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Anti-tumor chemicals have been found to be effective against surface neoplasms, both benign and malignant.

## Topical Chemotherapy of Cutaneous Neoplasms

JOHN A. CAVINS, M.D.  
Indianapolis

UNTIL recently, premalignant and malignant cutaneous tumors have been treated primarily by cauterization, excision or irradiation. During the past nine years, the technique of topical application of anti-tumor agents has been developed by Klein<sup>1, 2</sup> and others<sup>3</sup> for use in patients with multiple, superficial basal cell carcinomas (BCE), squamous cell carcinomas in situ (SCC), and actinic keratoses.

### Preferred Drug and Use

Several anti-tumor drugs have been studied with respect to topical application. To date, the most effective agent has been 5-Fluorouracil (5-FU). Complete response has been noted in approximately 98% of the lesions treated—comparable to that obtained with surgery or irradiation of single lesions. Concentrations of 1%—5% in propylene glycol, and 5%—20% in a hydrophilic cream base have been pre-

pared. At present, 2 and 5% 5-FU in propylene glycol, and 5% 5-FU in ointment base are commercially available for the treatment of actinic keratoses.\* Higher concentrations remain on an investigative basis. The experience of Klein, Cavins and other has shown that 5% ointment is effective against actinic keratoses and facial BCE, whereas 20% ointment is required for BCE and SCC over the trunk and extremities. Solutions of 1% and 5% are roughly equivalent to 5% and 20% ointment respectively, although 20% ointment has been found to be superior to the solution in the treatment of BCE and SCC in areas other than the facial region.

### Methods

The ointment is applied by the patient to the tumor-bearing area of the skin. The area is moistened slightly prior to application of the ointment, with the medication being applied with a gentle spreading motion without pressure. Protective finger cots are not necessary but

can be used if the patient so wishes. The ointment is applied twice daily for a period of from three to six weeks. Initially, moderate erythema of the lesion is noted, followed by anti-tumor response with crusting and eventual re-epithelialization about the reactive area. Selective eradication of premalignant and malignant tumors occurs without effect upon surrounding normal skin. The patient is advised that a given lesion may show an apparent increase in diameter that is representative of its true size prior to treatment but not detected visually, and that he should not be surprised at the appearance of new reactive spots in the area treated which represent previously undetected keratoses or tumors. Residual pigmentation may appear, but usually recedes in several weeks. Although no adverse effects have been noted in over 1,000 patients, careful follow-up is maintained, including frequent blood counts. Therapy is maintained to the point of obvious re-epithelialization, at which time it is stopped. Visual evidence of skin irritation is usually much more evi-

\* Efudex—Hoffman LaRoche, Inc., Nutley, New Jersey.

dent than subjective discomfort. Topical steroid ointments are available and can be prescribed if necessary. Within four to six weeks after discontinuation of therapy, the crust falls off, and the treated area assumes the appearance of skin normal for that patient. Careful follow-up is maintained on all patients, with evaluation every three to six months advised to detect and treat new lesions.

### Leukoplakia

The concept of topical chemotherapy has been extended to pre-malignant mucosal tumors—leukoplakia of the oropharynx and vulva.<sup>4, 5</sup> Preliminary work indicates that application of 1%—5% 5-FU over periods of one to twelve weeks can effectively eradicate existent

disease for indefinite periods of time. Long-term follow-up will be necessary to determine the permanence of the results of topical management of leukoplakia. The need for surgical excision may be delayed or eliminated, thus reducing the number of procedures that the patient will undergo.

Topical chemotherapy of pre-malignant and malignant skin and mucosal tumors continues to be a research and clinical interest of the author and associates. The intent is to establish a program for research, advanced treatment and dissemination of information for the routine treatment for multiple, superficial, cutaneous neoplasms.

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# Basic Understanding of Acupuncture\*

WEI-PING LOH, M.D.  
Gary\*\*

ACUPUNCTURE is a 5,000-year-old Chinese art of healing and has established truth and scientific uses. It is not a medical hoax. "Acus" in Latin means "needle." Acupuncture is a method of treatment involving application of needles to body surface and superficial tissues in order to induce anesthesia for operations and treatment of many ailments. The values of acupuncture have been recently documented by American medical authorities<sup>1</sup> who witnessed the treatment in mainland China and later reported their views on medical television programs and in the *Journal of the American Medical Association*. Other publications<sup>2,3,4</sup> also indicate the values of acupuncture.

## History

There are two major types of acupunctures: the old type involving application of burning moxa plant at outer end of the needle (known as moxibustion or thermoacupuncture) and the modern type involving application of direct electric current to twitch the inserted needle (also known as electroacupuncture). Historically stone needles were used at the beginning during pre-Christian eras. Metal needles (stainless steel, less commonly gold or silver) were then used during later periods. Articles on acupuncture are easily found in the Chinese history from the Han period to 18th century A.D.

During the T'ang period acupuncture reached Japan and then spread into Korea and India. In Europe the acupuncture method first appeared in London in 1683 and in Paris in 1735. Acupuncture has been known for centuries in European countries and even the Soviet Union established a separate department in their Academy of Sciences for systematic research on acupuncture. Rapid advances and wide applications began approximately 15 years ago when mainland China succeeded in applying direct electric current to acupuncture needles. Only in recent months has the acupuncture method been popularly discussed in the United States.

## Technique and Uses

Technically, the method involves insertion and manipulation of sterile needle or needles through specified points on body surface. The needle is generally inserted at a specified angle with twirling movements and the later manipulation is now maintained by a direct electric current or a biphasic pulse generator which delivers 6 to 9 volts with a discharge rate of 100 to 180 cycles per minute for the vibrations. The body surface has at least 361 major puncture sites which are connected by 14 major meridians (nerve pathways) under the skin (Fig. 1). Those structures are separately related to internal organs. Expert knowledge and experience is essential for proper selection of puncture sites and successful acupuncture anesthesia. The needle generally reaches a depth of a quarter to a half inch and, when the needle is properly inserted, the patient would have a numb and hot sensation in the area designated for surgery. Deeper insertion, reinsertion and rotation of needles may be required. Three needles inserted below eye, behind ear and on top of head, respectively, are generally required for removal of

brain tumor. One needle in each forearm is needed for thyroid operation. Four needles in the pinna of each ear are adequate for removal of stomach. Needle around jaw or behind the ear and another needle in the arm are required for lung operation. Needles in backbone and lower limbs are generally used for removal of an ovarian cyst or a pelvic organ.

Acupuncture alone is sufficient to induce anesthesia for operation in approximately 90% of cases. Inadequate anesthesia or even failure could be encountered in remaining 10% of the cases. The outlook is constantly improving, particularly for women's diseases, eye, ear, nose and dental cases. It has been widely used for Caesarean sections, tonsillectomy and removal of discomfort in a wide variety of ailments, including headaches. Adequate anesthesia may last up to six hours, and the anesthesia may persist for hours after withdrawal of the needles.

## Advantages

Acupuncture has many advantages over the conventional drug and gas anesthesia. In the first place, acupuncture, when properly administered, is absolutely safe. No serious complication was encountered in more than 400,000 operations with acupuncture anesthesia performed in mainland China. The conventional drug and gas anesthesia carries a risk of one death in every 3,000 cases; on this basis, the 400,000 acupuncture anesthetics have saved 133 patients from conventional anesthetic death. Second, acupuncture anesthesia is much cheaper. Third, less effort is needed in training for mastering the use of acupuncture. Fourth, the patient does not have to be fasting and does not develop nausea, vomiting and interruption of hydration. All those factors help to reduce the du-

\* Written for publication on May 22, 1972.

\*\* Dr. Loh is the Chief Pathologist for the Gary Methodist Hospital and the Lake County Coroner's Office, 600 Grant Street, Gary 46402. He is also a Clinical Associate Professor at the Chicago Medical School.



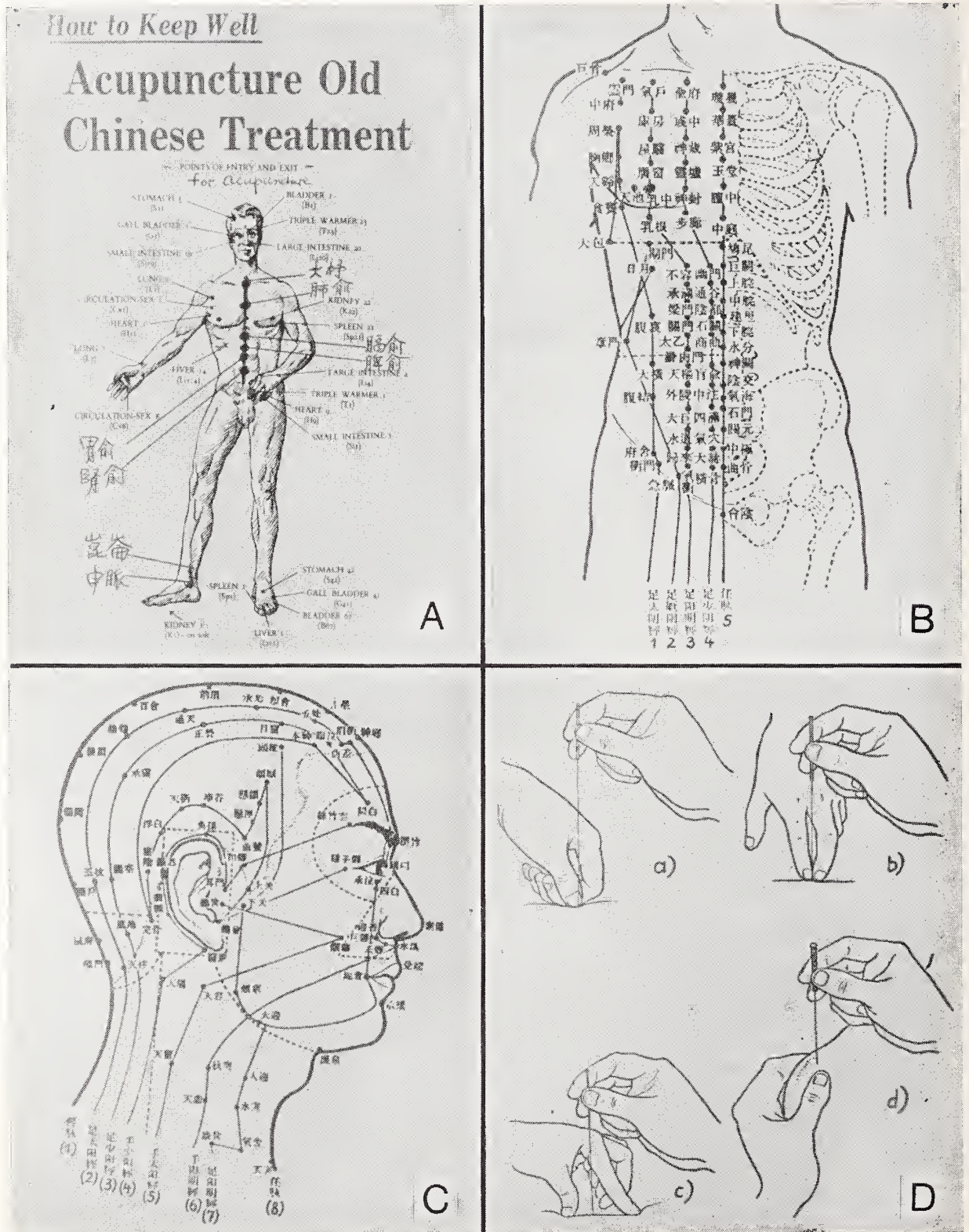


Figure 1

A, B, C: diagrams to indicate puncture sites and meridians through body surface.  
D: insertion and manipulation of needles (Courtesy of Herder and Herder, Inc.).



ration of his hospital stay. Fifth, the patient is fully conscious and can cooperate during the operation. Therefore, the regular care in a recovery room may not be needed. Sixth, acupuncture anesthesia gives no after-effects and postoperative complications. Finally, the acupuncture method is convenient and can be made readily available.

Problems

There are a few problems in the use of acupuncture. A few patients confirmed discomfort in the form of "pulling sensation" when a large mass was removed. Psychotherapy is helpful in those cases. Small areas of ecchymosis may be encountered at puncture sites. Naturally, acupuncture anesthesia alone may not be successful in a few cases, particularly due to lack of relaxation of thick abdominal wall and adhesions around organ being removed.

Comment

The mode of action of acupuncture has been partly explained in the aforementioned paragraphs. It is well known that disease of internal organs may cause pain in specific area of body surface through poorly identified nerve pathway; in this connection, proper stimulation of body surface and superficial tissue in the specific area (or even applying pressure or pinching) may suppress pain in the diseased organ. Another explanation is that twirling of the acupuncture needles creates a flood of painless sensations which race to higher nerve centers in thalamus portion of brain and spinal cord so that painful sensations from surgery are jammed and cannot reach the same higher nerve centers. Much research is still needed in order to confirm and to understand the many puncture sites and meridians and their relations in the body.

In conclusion, acupuncture has established value and distinct advantages as an adjunct to conventional drug anesthesia. It has potential medical uses in the treatment of many ailments. Over-enthusiasm and improper use without adequate training and experience are, however, harmful.

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INDIANA STATE BOARD OF HEALTH  
MONTHLY REPORT — July 1972

Disease	July 1972	June 1972	May 1972	July 1971	July 1970
Animal Bites	1345	1732	1277	1445	1470
Chickenpox	123	436	658	96	36
Conjunctivitis	205	260	254	282	157
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	22	38	22	46	26
Gonorrhea	866	1114	634	834	824
Impetigo	182	159	80	176	171
Infectious Hepatitis	51	50	53	42	45
Infectious Mononucleosis	44	73	126	42	44
Influenza	688	565	705	820	206
Measles					
Rubeola	37	115	219	135	22
Rubella	44	68	103	103	77
Meningococcic Meningitis	0	1	1	1	0
Meningitis, Other	0	9	1	6	3
Mumps	50	82	126	150	103
Pertussis (Whooping Cough)	10	4	79	13	15
Pneumonia	213	382	357	286	209
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	708	903	1114	580	455
Syphilis					
Primary & Secondary	17	13	14	44	38
All Other Syphilis	93	157	85	125	170
Tinea Capitis	2	3	2	0	1
Tuberculosis (Active)	35	59	57	60	102

# Ophthalmomyiasis (Eye Worms): A Case Report

N. F. RICHARD, M.D.  
Angola\*

LATE one Saturday afternoon a young mother brought her 3-year old daughter to the Emergency Room stating that the child had worms in her right eye. When the Emergency Room nurse reported this to me, I was certain that I was dealing with an hysterical mother. Close questioning revealed that while at a local laundromat the child complained of irritation of the right eye and began rubbing it. The mother examined the eye and said she saw little worms in it which would move and then disappear behind the eyeball. This latter, I explained to the mother, was an impossibility and told her about the anatomy of the palpebral and global conjunctiva. I did, however, examine the eye of the struggling child but, outside of a mild conjunctivitis, I could see no foreign bodies and no abrasions. A few drops of 10% Sodium Sulamyd were instilled and the mother was reassured and told to bring her daughter back if it continued to bother her. This came about sooner than I had anticipated. Within an hour the Emergency Room nurse again called me and said the mother had taken the girl to another hospital and, although not examined by an M.D., the nurse at that institution had observed the worms. In addition, our Emergency Room nurse also had seen the little "varmints."

Again I examined the eye, this time using a magnifying loupe. To my utter dismay I saw a tiny transparent object moving rapidly from the nasal side of the globe toward

the cornea. The object was approximately 1 mm in length and very thin. Now I was amazed and confused, because after practicing medicine for 33 years, I thought I'd seen about everything. I quickly called two colleagues who also admitted that they had never heard of such a condition. It was not until I telephoned an ophthalmologist in a nearby city that I received any help. Although he had never seen a case in his private practice, the ophthalmologist did recall seeing a patient with this condition during his residency in a large hospital. He said the condition was called ophthalmomyiasis and can be very dangerous to vision because the organisms sometimes invade the eyeball itself. He kindly agreed to see the child at once. I found out later that she was given a general anesthetic that evening and the organisms were removed by irrigation, the use of forceps and moist cotton swabs. Subsequent examination by him revealed no further difficulty with the eye.

Ophthalmomyiasis usually is caused by the first stage larvae of the bot fly (*Oestrus ovis*), especially in the United States. The larvae of other flies, however, may be involved, including those of the Russian gadfly, *Rhinoestrus purpureus*,<sup>1</sup> and those of the genera *cuterebra*,<sup>2</sup> *Sarcophagidae*<sup>3</sup> and *Muscidae*.<sup>3</sup>

The larvae of *Oestrus ovis* commonly infest the nasal passages of sheep and goats but occasionally produce ophthalmomyiasis in humans. The method of transfer from the female fly is thought to be by mid-air ejaculation into the eyes or nasal passages of the recipient al-

though some patients had stated that the fly actually touched the eyeball. It is also quite possible that the larvae may be transferred to the eyes from contaminated fingers. Usually the larvae remain in the nasal passages of sheep for several months, after which they fall to the ground and enter the pupal stage.

This strange malady, fortunately, is not so often seen in the United States as in other parts of the world such as the Middle East, India and Africa. Scott,<sup>4</sup> of the United States Public Health Service, reviewed 111 cases of myiasis reported from Canada and the United States from 1952 to 1962. In an interesting report by Brown, Hitchcock, and Foos<sup>5</sup> it was brought out that about 15 cases per year from Catalina Island are treated at Avalon.

Ophthalmomyiasis externa, where the larvae infest only the conjunctiva of the globe and lids, is much more common than ophthalmomyiasis interna, where the larvae actually penetrate the eyeball itself. Hunt<sup>6</sup> presented an unusual case which ended favorably and stated that the first such case was reported by DeBoe in 1933. In this article he also referred to Anderson's review of the world literature on this subject in the *American Journal of Ophthalmology* 18:699, 1935.

Even though I am not an ophthalmologist, I found this case to be quite interesting. Moreover, it has taught me a certain amount of humility. Never again will I make circular motions at my right temple with the tip of my index finger when a mother tells me her child has worms in his eyes.

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## From THE JOURNAL 50 Years Ago

This report comprises the most of the cases of this type seen and treated by Dr. Edwin Walker and myself and other members of the Walker hospital staff, during the years 1899 and 1920, inclusive. I have taken this period because it includes all my work except for the year of 1921.

There were a few cases operated in the home each year; some of these are included; those which are not mentioned either had no histories or they were lost. As time went on there were less operated in the home, as it is a certainty that the best results are obtained in the hospital, where all equipment is convenient and more experienced attention can be given the patient. However, our mortality in cases operated in the home is not bad. I do not expect every case to be brought into the hospital, because there are instances in which it is best for the patient not to be moved, so we are always ready to operate such a case in the home.

. . . . During the years covered by the report 1,761 laparotomies have been done and I am sure that the appendix was removed in seven-tenths of them. During the past few years we seldom open an abdomen without removing the appendix. It is interesting to know that 60% of all appendices show evidence of present or past infection. In gall bladder operations we do not always take out the appendix because in so many patients with a long incision there is a tendency for a gaping wound that is hard to close, so for this reason none except affected appendices are removed in gall bladder operative cases.

This series of cases covering a score of years shows variations in mortality; the causes are varied—a better surgical technique pertains in the latter half than in the first half. The physician treating the acute case now urges operation at once, wherein he formerly was more apt to follow the Ochsner treatment a few days under which treatment a certain number always became very severe—abscess or peritonitis cases. Then there is a growing tendency for people to heed the advice to go to the hospital early. The greatest factor in our decreased mortality is the "School of Experience" of the practitioner. After a physician sees one or two bellies opened which are badly stained with pus or show a badly necrotic appendix he can more forcibly persuade a patient to take radical treatment.—James Y. Welborn, M.D., Evansville, "Report of Appendicitis Cases," *JISMA*, Sept. 1922.

# Drug Interactions: Oral Anticoagulant Therapy and Self-Medication

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HERE have been many indications that maintenance of effective drug therapy in outpatients constitutes an increasingly more difficult problem. This is the result of a number of factors.<sup>1-3</sup> One such factor is the current frequency of self-medication resulting from changing social attitudes toward drugs and the perpetuation of such attitudes by the continuous advertising of nonprescription medications.<sup>4</sup> With the advent of synthetic drugs, the public has a bewildering plethora of over-the-counter medications from which to choose but an alarming lack of information concerning the potential hazards associated with the concomitant use of prescription and nonprescription drugs.

It is the intent of this discussion to provide information concerning the potential hazards associated with the concurrent use of oral anticoagulants and certain nonprescription medications, in order that both physicians and associated members of the health team will be better informed and thereby better equipped to inform the patient of potential adverse drug reactions associated with such combinations. To quote a recent editorial in the *Journal of the American Medical Association*, "When a physician prescribes a drug, he has an obligation to warn the patient about the drug's potential for causing adverse reactions, (and) for some patients (he) has a

similar responsibility to warn about the dangers of over-the-counter drugs."<sup>5</sup> This same philosophy is expressed by Martin in his discussion of factors affecting the prescribing of medications by physicians and the dispensing of medications by pharmacists.<sup>6</sup>

Prior to the discussion of the potential OTC drug interactions with oral anticoagulant therapy, a brief consideration of the magnitude of the problem provides ample justification for the consideration of such interactions. A study conducted in late 1969 and early 1970 by Stewart and Cluff on a randomly-sampled group of outpatients at the University of Florida Teaching Hospital provides an interesting profile on the utilization and interactions of prescription and nonprescription drugs.<sup>4</sup> These authors found that, of the patients who had taken medications prescribed by their physicians within 30 days prior to their clinic visit, 98 percent of these same patients had also self-administered nonprescription medications. The therapeutic types of nonprescribed medications in order of decreasing incidence of usage included analgesics, gastrointestinal preparations, vitamins, laxatives, and cough preparations. Analgesic preparations were the most commonly used class of nonprescription medications with 65% of those patients interviewed having self-medicated with some form of analgesic during the 30-day period prior to their clinic visit. Consequently, the incidence poten-

tial for adverse interactions involving oral anticoagulant therapy and self-medication is well substantiated.

The remainder of the discussion is limited to those potential interactions between oral anticoagulants and nonprescription medications. For those requiring a comprehensive review of oral anticoagulant interactions, a number of excellent recent articles are available.<sup>7-11</sup> Of the two chemical classes of oral anticoagulants currently in use, most interactions reported have involved the coumarin derivatives, primarily bishydroxycoumarin (Dicumarol) and warfarin (Coumadin, Panwarfin). Three other coumarin anticoagulants are available in this country, acenocoumarol (Sintrom), ethyl biscoumacetate (Tromexan) and phenprocoumon (Liquamar). However, there are few reported interactions with these compounds, due probably to the fact that their incidence of use is not as great as that of bishydroxycoumarin and warfarin.<sup>8</sup> The second class of oral anticoagulants in use is the indandione derivatives, anisindione (Miradon), diphenadione (Dipaxin) and phenindione (Danilone, Hedulin).

The coumarin and indandione derivatives have essentially the same mechanism of action in the body. They act to inhibit blood-clotting mechanisms by decreasing plasma prothrombin levels as well as clotting factors VII, IX and X. The basic mechanism of inhibition involves interference with the action

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of vitamin K which is required for the synthesis of prothrombin and other clotting factors by the liver.<sup>12</sup>

Certainly the interaction of greatest clinical significance is that of the salicylate analgesics. In 1943 Link demonstrated that salicylic acid induces a hypoprothrombinaemia in the rat which is reversible with vitamin K. The prolongation of prothrombin time is the result of a decrease in one of the clotting factors similar to that produced by bishydroxycoumarin.<sup>11,13</sup> Doses of salicylates in excess of 1 gm/day have been shown to significantly increase the Quick prothrombin time in humans.<sup>8,14,15</sup> In addition, aspirin suppresses platelet aggregation induced by collagen, antigen-antibody complexes, and certain other substances,<sup>11,13,16</sup> and the effects of a single aspirin dose may suppress platelet aggregation for up to 7 days.<sup>17</sup> Also, the occurrence of gastrointestinal hemorrhage and erosive gastritis produced by aspirin has been reported by many investigators.<sup>13,18,19</sup>

Salicylates have been reported to interact directly with oral anticoagulants by interfering with the utilization of vitamin K<sup>7</sup> and by displacing the anticoagulant from its albumin binding sites on plasma proteins.<sup>7,9,10,20,21</sup> Consequently, it is evident that the concomitant usage of salicylates and oral anticoagulants presents the possibility of potentially serious hemorrhagic complications and requires the patient's awareness of the potentiating effect of salicylates during long-term anticoagulant therapy.

It has been suggested that acetaminophen (Tylenol, Tempra) is a suitable aspirin substitute for use in combination with oral anticoagulant therapy.<sup>8,22</sup> However, recent reports indicate that acetaminophen will also potentiate the effect of anticoagulant drugs. Four anticoagulants (sodium warfarin, bishydroxycoumarin, phenprocoumon and an-

isindione) were administered in combination with acetaminophen (650 mg qid) for two or four weeks and an increase in prothrombin time was observed with each combination.<sup>23</sup> A subsequent study indicated that two 650 mg doses of acetaminophen four hours apart had no effect on the prothrombin time of patients on phenprocoumon.<sup>24</sup> Consequently, it would seem that intermittent use of acetaminophen in conjunction with oral anticoagulant therapy avoids the disadvantages of the salicylates discussed above. However, continuous use of acetaminophen may require adjustment of the anticoagulant dosage.

The study of Stewart and Cluff referred to previously indicated that approximately 35% of those persons interviewed took some form of vitamin supplements which had not been prescribed by their physicians. Generally these are multivitamin combinations containing both B complex and vitamin C. It has been reported that B complex increases prothrombin time and thus may cause hemorrhage with anticoagulants.<sup>25</sup> However, of greater clinical consequence is the interaction of vitamin C. Vitamin C has been reported to antagonize the effects of anticoagulants and thus to shorten prothrombin time.<sup>11,26</sup> The recent report of a case history emphasizes the clinical significance of such an interaction.<sup>27</sup> An outpatient was being maintained on warfarin and was having periodic prothrombin times to monitor anticoagulant activity. For several weeks the patient was stable and then suddenly the prothrombin times became significantly shorter. Upon extensive questioning it was found that the patient had been self-medicating with vitamin C for a cold. As soon as the vitamin C was discontinued the prothrombin times returned to the therapeutic range. This interaction is especially cogent in view of the recent publicity the lay press has

given Pauling's theories concerning vitamin C prophylaxis for the common cold.

Gastrointestinal agents including antacids, laxatives, lubricants, and stool softeners have also been implicated as potential interactants with oral anticoagulant therapy. For example, it has been suggested that large doses of antacids may reduce the absorption of coumarin anticoagulants.<sup>8</sup> Since the coumarin derivatives are acidic it is likely that smaller quantities would be absorbed as the contents of the gastrointestinal tract becomes more alkaline. Similarly, surfactants such as dioctyl sodium sulfosuccinate (Colace, Doxinate) may affect the rate and extent of absorption of the anticoagulant by solubilizing the drug within surfactant micelles or by affecting the permeability of the epithelial cells.<sup>25</sup> Cathartics, if given for long periods of time, may intensify the anticoagulant effect by interfering with the absorption of vitamin K from the gastrointestinal tract.<sup>28</sup> Mineral oil may interfere with the absorption of vitamin K and thereby enhance anticoagulant activity if it is given over extended periods. Conversely, it has been suggested that mineral oil may reduce the anticoagulant effect of coumarin by interfering with its absorption from the gastrointestinal tract.<sup>8,29</sup> Since it is often the older segment of the population that is maintained on long-term anticoagulant therapy and also this same population segment which resorts most frequently to use of the above gastrointestinal agents, the potential for drug interaction with this group of OTC agents should not be ignored.

The final OTC compound to be considered is quinine. In certain segments of the population it is still used for the relief of headache, neuralgia and fever, and has been included in a number of tonics and older cold formulations. Its use for the relief of nocturnal leg cramps,



remains probably its only justification for OTC sale, and it is often dispensed for this purpose. However it has been shown that a daily dose of 300 mg of quinine sulfate will significantly increase the prothrombin time in normal subjects within 3 to 6 days.<sup>30</sup> Quinine acts synergistically with warfarin and other oral anticoagulants by depressing the vitamin K-sensitive clotting factor synthesis in the liver.<sup>31</sup>

In summary, it is important to recognize that the potential for drug interaction does not mean that concurrent usage of two drugs is contraindicated, but rather that if the physician is aware of potential interactions he is able to counsel the patient when necessary on the hazards of self-medication and to adjust the therapeutic regimen based upon his knowledge of potential drug interactions.

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## Andrew C. Offutt— Gentleman and Scholar

Dr. Andrew C. Offutt will retire as Indiana State Health Commissioner on October 1, after being with the State Board of Health for 21 years, and having been its chief executive for the past 18 years.

Dr. Offutt graduated from Franklin College with an A. B. degree in 1933 and received the M.D. degree from Indiana University in 1940. He served as a medical officer in the U. S. Army from then until 1951 when he became associated with the State Board of Health.

His military service was varied and extended from instructional duties in medical field service at Carlisle Barracks to hospital planning and medical service programs in the European Theater and then back to the Medical Training Section of the Office of the Surgeon General after the war.

He was originally Director of the Division of Communicable Disease Control of the Indiana State Board of Health. Later he was also director of the Division of Tuberculosis Control. He was Director of the Bureau of Preventive Medicine for several months before becoming State Health Commissioner on September 1, 1954.

Dr. Offutt has discharged his duties as Commissioner with perspicacity and zeal. His energy, diplomacy, and unfailing good nature have been the hallmark of his administration.

In addition to the overwhelming number of routine duties, he has given time to medical writing and has participated generously in the affairs of the medical profession of the state.

He cannot be replaced by a single individual. He has served as chairman of the Ohio River Valley Water Sanitation Commission and the Indiana Administrative Building Council. He is the chairman of the Air Pollution Control Board of Indiana, the Stream Pollution Control Board of Indiana, the Radiation Control Advisory Commission for Indiana, the Advisory Hospital and Health Facilities Planning Council, and the State Anatomical Board.

Dr. Offutt is also Secretary of the Commission on Forensic Sciences, the Indiana Health Facilities Council, and the Hearing Aid Dealer Advisory Committee. In addition, he was a member of the United States delegation to the World Health Assembly in Switzerland in 1964.

The medical profession of Indiana and, in fact, all citizens of Indiana are indebted to Dr. Offutt for

his many years of sterling service in the interest of health and wish him the very best of everything in whatever activity his future provides.

## Generic Equivalence or Inequivalence

ONE of the reasons there is so little information on generic equivalence is that very little investigation has been done on the subject. While approximately 3,000 drugs were subject to the Drug Efficacy Study, only 12 drugs have been studied in man under controlled conditions to determine the rate or extent of bioavailability.

Dr. John G. Wagner, Professor of Pharmacy and Assistant Director for Research and Development, Pharmacy Service, University Hospital, Ann Arbor, has reported on equivalence or inequivalence in general and about the 12 drugs in particular.

Bioavailability is the important specification of any drug. Chemically equivalent amounts of a drug may be contained in several different formulations which will yield markedly different therapeutic results due to the differing speeds and extent of absorption.

Dr. Wagner reports that, for seven of the twelve drugs tested, large

differences were discovered in bio-availability. The seven drugs were riboflavin, acetylsalicylic acid, p-aminosalicylic acid, chloramphenicol, sodium diphenylhydantoin, tetracycline hydrochloride and oxytetracycline hydrochloride.

In the case of warfarin one 25-mg tablet was found to produce a blood level of only 80% of what would be produced by five 5-mg tablets of the same source. When tablets of warfarin from three different manufacturers were compared, they were found to be equally available but with about a fourfold difference in rate of absorption.

"Large differences" in availability are specified by Dr. Wagner in the case of p-Aminosalicylate, for example, for which the availability of different formulations varied from 41.8% to 99.4%.

"Large differences" in availability of chloramphenicol were tabulated as 10.9 average peak plasma concentration for the brand-name drug, as contrasted with 5.2, 6.3, and 2.7 for the generic preparations.

Similarly, the serum concentrations for a brand-name oxytetracycline when compared with generic sources shows universally a higher peak level, faster increment and slower dissolution in every one of 16 trials.

A Canadian manufacturer was asked to produce a dicoumarol tablet which could be easily halved to make half-doses possible. More inert filler was added to make the tablet larger and easier to break. Even though the old and new tablet had the same amount of dicoumarol, the larger tablet was ineffective. When the "new" tablet was reformulated it became more effective than the original and produced bleeding. It was finally determined that each patient should be titrated with respect to dosage whenever another formulation was prescribed.

No doubt many more drugs will be studied for equivalence in the

future. So far, it would seem that inequivalence is the rule and equivalence is the exception.

### **Substitution Disfavored by AMA Physician-Pharmacist President Hoffman**

Charles A. Hoffman, M.D., president of the AMA, was a practicing pharmacist before he attended medical school. Naturally he is aware that some pharmacists are attempting to establish the right of pharmacists to substitute without limit when filling a prescription. And, also naturally, he views this situation with some discomfort.

Every legal jurisdiction in the United States has either a law or a regulation which prohibits substitution without the prescriber's knowledge and consent. The American Pharmaceutical Association is sponsoring the repeal of these regulations and laws, and is doing so rather vigorously.

The reasons given for this stand are that the right to substitute without permission would enhance the professional stature of the pharmacist and would provide a financial advantage for the patient.

Dr. Hoffman, in commenting on the subject recently in the *American Druggist*, pointed out that it is well known that physicians, nurses and dentists are specializing today in order to concentrate a rapidly growing body of knowledge on clinical problems. He then emphasizes that "the pharmacists, proud of their professional skills, who are agitating for the right to substitute one drug for another on a physician's prescription are running counter to this trend."

"They believe they are capable, apparently, of performing not only their own professional duties, but also those of the physician—without examining the patient. They deny the expertise of the specialist who

did the prescribing and who is fully aware of the physical condition of the patient."

"These same pharmacists are also down-grading their own profession as it is practiced now. They are saying, in effect, that their highly specialized, detailed knowledge is not being used properly. But, in my opinion, pharmacy is an honored profession, fully utilized in health care delivery. I turn to the pharmacist when I need detailed, professional assistance in drug therapy. It is to the pharmacist that I turn when I need special mixtures for a patient."

"I cannot believe that the druggists of today are willing to take on additional responsibilities and costly liabilities without a commensurate increase in income. This, however, is the unbusinesslike attitude which the repeal forces have apparently decided to take."

Dr. Hoffman doubts that any amount of substituting drugs would result in an economic saving for the patient since the druggist's expense of doing business would be considerably higher. He says: "The first new operating cost that would confront pharmacists with the passage of repeal would be the purchase of liability insurance. . . . Rates for pharmacists would necessarily be astronomical because they would, in effect, be prescribing for patients without the benefit of examination, or the physician's specialized knowledge."

Some brand name drugs do not have generic equivalents. Many factors concerned in the compounding of drugs have a profound effect on their therapeutic effect. It is better that the patient get exactly what the doctor orders.

It is difficult to understand how the professional status of a pharmacist would be raised by having him furtively change a prescription without the physician's knowledge.



## Nation's Loss of Confidence May Stem from Utopian Dreams

Maybe the crisis of confidence we as a nation are experiencing today stems from the implicit utopianism of many cries of reform, the notion that man is capable of perfecting himself and his society. In my view the danger of this assumption in politics is that if society is clearly seen to be perfectible, one is justified in adopting rather stringent methods to perfect it. When these solutions fail they often generate even more extreme measures and ultimately devolve into authoritarianism. We read this lesson in the grim annals of the French and many other revolutions.

The threat of autocracy may seem remote and it probably is. But there are more immediate shoals on the voyage to Utopia. One is the loss of perspective. If it is possible to legislate absolute equality of opportunity, to ensure perfect justice, to gain total freedom, then any mere approximation of these ideals must seem like an insidious compromise. Progress then is not measured for what it is but rather in terms of failure to achieve the ultimate. The result is despair. Blind idealism ensures that some will cop out, will quit the moral battlefield when disappointments sets in—as it always does.

To say all this is not to deny the importance of action, but to insist upon responsible action. . . .

The main task of those committed to a better life is to be rigorous and yet sensible, determined to aim high yet refusing to fall for Utopian "solutions" that are bound to disappoint in the long run. We cannot return to an idyll of pastoral simplicity. We will not be able to restore the conditions of 1492 or 1620 or even 1776, and we should not expect to reach some ideal standard of pristine purity.

—From a speech by WILLIAM D. RUCKELSHAUS, administrator of the Environmental Protection Agency.

### Mr. Ruckelshaus Is Right

Utopianism, as expounded by William D. Ruckelshaus, administrator of the Environmental Protection Agency (see adjacent column), is exerting an unfortunate effect on health care as well as on other segments of American life.

Unrealistic expectations are never realized. Disappointment is the inevitable result of planning for or of being promised the impossible. One of the biggest reasons that Americans are disappointed with medical care is that they expect too much.

Americans have been talked into being perfectionists when it comes to medical care. A perfectionist is always dissatisfied—to him "almost perfect" is a disaster.

Because of marvelous advances in medicine many people tend to expect the impossible. The installation of special rooms for recovery from anesthesia has, no doubt, saved many lives and prevented many complications. However, this area in the hospital, despite its life-saving quality, has become a nidus for negligence suits, as witness the tremendous increase in insurance premiums for anesthesiologists. The public has not been satisfied with a substantial improvement in this area; they have demanded perfection.

When the American Cancer Society adopted for its slogan "Cancer Is Curable," the inference to a reasonable man was supposed to be that, with early care and proper treatment, "some cancers are curable." However, the slogan, which was meant to be encouraging, proved to be a cruel disappointment to some who expected too much. One father, whose child died of leukemia, based his claim of medical negligence on the facts as he saw them. "We took the child to the

doctor the first day she had a symptom and now she is dead. They say cancer is curable. The doctors didn't try to get her well."

Plans for universal medical care are suffering from the same type of misunderstanding. Lyndon Johnson is quoted as saying something to the effect that "This country is big enough and rich enough to provide top-notch medical care for everyone." This sounds nice—it produces a warm glow—it might easily produce some votes—it is powerful enough to make a big increase in taxes popular. It has only one defect; it is not so. Medicine has advanced to the point at which its complexities and its costliness are so high that it cannot be applied to everyone in its fullest form.

There is not enough money in the world to furnish the American people with all the first class medical care they would absorb if it were to be supplied without limit.

Utopianism is carrying those who plan American medical care into a jungle of impossibilities. Unless our planning is done with more realism we will end up with a standard which is not possible to attain.

As Mr. Ruckelshaus says: "Progress then is not measured for what it is but rather in terms of failure to achieve the ultimate."

### The Drug Package Insert

There is a mistaken belief on the part of some individuals that the information in the drug package insert constitutes the only legal and proper rules for the use of the drug.

This mistaken belief, on amplification, states that the use of any drug in dosages outside the limits suggested in the package insert is illegal and reprehensible. The same opinion is applied to therapeutic indications, dosage schedules and type of patients to be treated, if such use is not specified in the insert.

Package inserts contain valuable information. By regulation they are legally a part of the labeling. Their basic purpose is to inform physicians about properties of drugs.

The insert is written by the manufacturer in such a way as to obtain the approval of the FDA. The information in the insert is obtained by clinical investigation and is contained in the New Drug Application which, upon FDA approval, releases the drug for general sale.

Since the insert is written by the people who have had the longest and most intense contact with the drug, the information often is available only thru the insert.

However, since it is written by the manufacturer as a promotional piece and since it, inevitably, reflects FDA policies, it may be inaccurate, incomplete, and even misleading.

An excellent review of the subject appeared in the June 12, 1972, issue of *JAMA*. It is authored by John Archer, M.D., of the AMA Department of Drugs, who has granted permission for reproduction of the article in full at a later time.

In discussing the package insert, Dr. Archer says: "I believe the documents should be read, but with an understanding of their overall purpose and within the perspective of other sources of medical information. They should be evaluated with a view to how well they reflect prescribing standards, but they should never be allowed to set those standards."

Also: "The regulation of the practice of medicine involves a large body of laws, statutory and common, federal and local. Ethics and standards of competence set by the profession itself are equally demanding, but nothing in the Federal Food, Drug, and Cosmetic Act constrains a practicing physician to have his medical decisions determined by a pharmaceutical com-

pany and the FDA through a package insert that the physician has been no party to preparing."

Dr. Archer warns against the use of the term "FDA-approved uses" of drugs. "The FDA does not approve uses of drugs once they are on the market. It approves what a manufacturer may say about these uses in its advertising and its regulatory monograph."

The complete text of this article will be published in a later issue of this journal.

### Tips from the Tower

*The Journal* is inaugurating a new feature—"Tips From The Tower"—a monthly column for clinical subjects which are suitable for brief discussion. The column will be edited by Dr. A. Alan Fischer, director of the Family Practice Program, Indiana University School of Medicine. It will be written, in response to questions and requests of the readers, by members of the faculty of the School of Medicine. Requests are invited from readers of *The Journal*. Inquiries related to general medicine or any of the various specialties will be welcome. Correspondence should be addressed to Tips From The Tower, c/o Dr. A. Alan Fischer, Family Practice Program, 1100 W. Michigan St., Indianapolis 46202.

### Not "Should" but "Can"

LATE in 1971 spokesmen for the Food and Drug Administration began to suggest that information on the comparative usefulness of medications should be included in the labeling on drug packages. Since then "relative efficacy" has been promoted with increasing vigor.

Such a stand is in sharp contrast to the FDA attitude in 1962 when Congress was amending the Food, Drug, and Cosmetic Act. At that

time Secretary Ribicoff was asked if FDA wanted the power to decide relative efficacy. He said: "We do not seek it. We do not want it. We do not want to say that drug A is better than drug B."

Actually the question is not **should** the government provide ratings for drugs. The question is **can** the government perform this function.

It would simplify the physician's task considerably if a government bureau could arrange, for example, all the drugs in use against hypertension in order of efficacy. However, this is, obviously, an impossibility. Many controlled studies have failed to show any significant difference in efficacy between major anti-hypertensive drugs. Despite this, all such drugs are used clinically and are valued because individual patient differences make each of them peculiarly essential in differing circumstances.

Legislation is now pending which would prevent the marketing of any drug not proven to be better than those already available. The first thiazide diuretic would have been the only one if this law had been in effect when it was first introduced. Researchers have made only slight modifications in the thiazide series since, but have found more than a dozen diuretics, each with a difference which is significant when the patient needs something a little different.

"Do the American people want FDA deciding when the last diuretic has been discovered, or instead do they wish to see further research leading to improved diuretics?"

A number of drugs have been introduced when found to be moderately effective for a special indication and, after years of use, have been found to be smash hits for some other indication. For example: lidocaine in cardiac arrhythmia. Under the proposed law lidocaine



might not have survived in competition with novocain as a local anesthetic agent. In a free market, however, it has competed and survived and now is a valuable cardiac drug, also.

The 1969 Drug Efficacy Study said: "The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."

This is the process that is responsible for the large number of steroids of value in contraception, and in the development of antithyroid drugs. Seemingly trivial differences in a drug not infrequently make major differences to patients—and make arbitrary relative efficacy judgments impossible.

The four main factors in a therapeutic relationship are: (1) Physician prescribes (2) drug against (3) disease of (4) the patient. The notion of relative efficacy assumes that, for a given disease, drugs can be ranked independent of physician and patient. This assumption is false. Recent discoveries suggest that the individuality of the patient, and of the physician, plays a very important role in determining the effectiveness of drug treatment.

(Abstracted from a memorandum on relative efficacy prepared by the Pharmaceutical Manufacturers Association. The PMA invites comments of physicians. The address is 1155 Fifteenth St., N.W., Washington, D.C. 20005.)

## Editorial Notes . . .

**The publication of the first report of the A.M.A. Study Group on Medical Planning is a signal event. Perhaps the most important thing about it is that it helps to dispel the image of the A.M.A. as a rigid and reactionary body with no room in its ranks or on its councils for the**

**original or "different" thinker. Of course the Association must have its firm policies, determined by majority opinion, and the incorrigible individualist must expect to feel uncomfortable at times, if he insists on keeping out of step. But some of the Association's most valuable, and valued, members and office bearers over the years have been constructive thinkers who had the wit to bring forward genuinely new ideas while remaining free from the arrogance that could not take a knock-back.**

Sound like comment about the American Medical Association? It could be; but, as a matter of fact, it isn't. The above concerns the Australian Medical Association, and was published recently in their journal. Medical associations must be the same everywhere.

**The electronic transmission of an electrocardiogram, if it is accurately done, will serve in many circumstances such as the monitoring of a patient while being transported to the hospital or the monitoring of an ambulatory patient during the period when ambulation is first prescribed following an acute occlusion.** Astronauts on the moon are monitored in this manner. Recently an ECG record was transmitted from Stanford University to a satellite over Manila and then back to Stanford, a distance of 51,000 miles, without distortion.

**The type of immune response which rejects transplanted hearts might be useful, if it could be developed in humans, to reject malignant neoplasms.** Cellular-type immunity will reject tumors or foreign tissue. Antibody-type response, as illustrated by gamma globulin, is not effective against neoplasia but is the type which usually develops when the body is challenged by cancer antigens. Two Chicago pathologists working with guinea pigs

have succeeded in changing the immune response to the cellular-type. Work will continue to adapt the process to the human.

**The American College of Physicians recommends that a massive public education campaign be conducted to acquaint the public with the resuscitation measures useful for victims of coronary heart attacks.** Treatment of cardiac arrest, if performed quickly and efficiently, will often save a life. More than half the coronary occlusion deaths occur before the patient arrives at the hospital. The initial treatment is most important.

**The Humble Oil Company has developed a new mosquito larvicide which is cheap, non-toxic to other life and does not permit the development of resistance, a phenomenon which has all but eliminated DDT as a mosquito controller.** It has been named Flit MLO. It does not chemically resemble the once popular "Flit," but carries the name because of related function. Humble emphasizes the seriousness and size of the mosquito problem by relating that the mosquito is the most adaptable form of life on the earth today, is the most numerous of all animal forms and transmits a variety of serious diseases. The total weight of all mosquitoes exceeds the total weight of all other animal life combined.

**Restricted formularies do not necessarily reduce the health care bill.** Economy is the main argument which supports the move to generic prescribing, enlists enthusiasm for repeal of ant substitution laws, and furnishes backing for formularies. The economy advantage simply is not there—it is an illusion. The University of Wisconsin school of pharmacy reviewed the experience of 19 states over a period of four years from 1967 through 1970. Some of the states had formularies, others did not. The states with re-



stricted formularies spent more on a per capita basis for total medical care than did the other states. Dr. Robert Hammel, who did the survey, points out that the drug bill is a relatively small part of the health bill but it is possible that the right drugs used in the right way may influence the total health care expenditures. The administrative expense of operating and enforcing a formulary probably costs more than is saved in the drug bill.

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**C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, recommends that the FDA examine and remodel drug advertising regulations.** Stetler thinks that the ads are not helpful because the information on drug side effects is so detailed it clutters the message to the point of making it useless. He says: "It is very possible to bring about genuinely valuable communication on these subjects, without unwarranted claims, and, just as important, without a parade of every trivial testimonial side effect that ever surfaced in the history of the medication."

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**The number of full-time pharmacists in hospitals increased from just under 5,000 in 1957 to more than 16,000 in 1971.** More pharmacists practice today in short-term hospitals with over 500 beds than practiced in all sizes and types of hospitals in 1957. The big reason is the change to 24-hour-a-day-every-day service. Don E. Francke, Editor of DRUG INTELLIGENCE & CLINICAL PHARMACY, comments that "A five-day, 40-hour period of patient service with none on Saturdays, Sundays and holidays shortchanges the patient, the nurse and the physician, and makes the pharmacist quite dispensable."

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**An article in a recent issue of "Archives of General Psychiatry" enumerates the differences in heroin**

**addiction in army personnel in Vietnam and in standard stateside addicts.** Heroin in Vietnam comes in purer and stronger form, is smoked, snorted or swallowed, and is characteristically used by groups. Heroin in the U.S. is dilute, hard to get, expensive, usually used by intravenous route, and the addicts are loners. Salvage and rehabilitation procedures should be different in the two groups.

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**The Pharmaceutical Manufacturers Association has asked that jurisdiction over regulation of drugs be removed from the proposed Consumer Safety Agency now being considered by Congress.** The objection to the bill is that in placing major stress on the need to avoid "risk," the bill would provide for civil penalties against the new agency if it approves the marketing of a product which is found to constitute a safety hazard. Since every prescription drug presents some safety hazard, Mr. Stetler said, the result would likely be that no approvals would be issued for new drugs at all.

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**University of Rhode Island biochemists have demonstrated that vitamin K exists in two forms in the body, one active, the other inactive, and warfarin blocks the action of vitamin K by blocking conversion from the inactive to active form.** This new discovery does not explain why some rats are immune to warfarin action and do not bleed when fed large doses. Further investigation is being done to find whether there is a mutation in the enzyme which converts vitamin K.

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**The law which governs the amount of the VA grant which may be given for purchase of a car by a disabled veteran has been changed.** The purchase grant has been raised to \$2800 and, for the first time, the VA may pay for replacing and

maintaining adaptive equipment on automobiles previously acquired by disabled veterans.

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**The Earl of Snowdon is credited with the invention of an electrically powered mobile platform for the disabled.** He calls it a "Chairmobile." It does not look like a conventional wheel chair. It will turn around completely on its axis, is small enough to get through a standard size door and can even fit into a small bathroom. Operates on a battery powered motor.

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**Dr. Donald Shumrick, professor of otolaryngology at the University of Cincinnati, has successfully reconstructed a functioning larynx in dogs.** The larynx is fashioned from the animal's own tissue. It will function as a real larynx would in relation to breathing, eating, swallowing and speaking. Dr. Shumrick is now working with baboons with a view toward reconstructing a human larynx later.

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**Recommendations by safety organizations for enactment of state laws requiring the use of safety belts by all motorists are increasing.** About eight out of ten cars have safety belts available. It is estimated that only one out of three use seat belts and only one in ten uses a shoulder harness. The National Safety Council estimates that between 2,800 and 3,500 lives were saved last year because of the use of belts—6,500 more could have been saved if all belts had been properly used.

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**New York City reports that marijuana prosecutions have diminished considerably during past few months but cocaine arrests are away up.** Cocaine is more expensive than heroin and just as deadly. ◀



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**Warnings:** Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with possible loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

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**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males

with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

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**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

**Dosage and Administration:** The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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# The 1972 Student-Faculty-Physician Retreat

Jerry A. Royer, M. D.,  
Ross L. Egger, M. D.,  
Steven C. Beering, M. D.  
Indianapolis\*

Last January, a group of students, practicing physicians, and faculty participated in a weekend retreat sponsored jointly by the Indiana State Medical Association and the Indiana University School of Medicine. The goal for the retreat was to identify ways to make medical education more relevant to health care. The conference format emphasized small-group activity, workshops focused their problem-solving on three aspects of medical education: the admissions process, educational models, and proposed changes in medical school teaching.

## Arriving at a Format for the 1971-72 Retreat

The format for the 1971-72 Student-Faculty-Physician Retreat evolved from the experience of similar retreats the preceding two years. Since the inaugural retreat (September 1969) and its successor (1970) effectively brought together students, faculty, and physicians for information exchange and rapprochement, and since both retreats delineated problems in the medical education and medical care systems, the consensus was that any future retreat should be more structured, more problem-solving, more action oriented. Accordingly, the planning committee met four times during

the fall months of 1971 to design a retreat format which might identify solutions to those problems delineated the two previous years.

At its first meeting, the planning committee proposed the following:

1. *Theme:* How can medical education become more relevant to health care?
2. *Tentative format:* A two-day event at retreat site in the Indianapolis area.
3. *Action plan:* Conclusions of the retreat to be framed in the form of specific recommendations to the President and the Board of Trustees of ISMA, to the Commission on Medical Education and Licensure of the ISMA, to the Executive Committee of the IUSM, and to the Education Committee of the IUSM; a half-day follow-up meeting six months after the retreat to review the results of the retreat and the extent to which recommendations had been considered or implemented by the two sponsoring groups—the ISMA and the IUSM.
4. *Invitees:* 15 persons each from four groups—students, faculty, physicians, and housestaff.

At the second meeting of the planning committee, Dr. Beering presented as a possible tool for the retreat a problem-solving format devised by Dr. Andre Delbecq. This process, which Delbecq calls the Nominal Group Process, proves an efficient means of brainstorming and

prioritizing a broad range of solutions for a given problem.\*

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\*Delbecq deals with the relative effectiveness of *interacting* (spontaneous group discussion) versus *nominal* (individual silent effort in a group setting) group processes for problem-solving committees. The former, the interacting group, is defined as a group in which all communication acts take place between members with minimal controls or formal structuring. The nominal group, on the other hand, is defined as a group in which individuals work in the presence of others but do not verbally interact; typically, some written output is obtained from each participant. The author concludes that there exists an optimal combination of group processes for problem-solving: 1) the use of nominal group processes for fact finding, idea generation, or initial subjective probability estimation—the first phase of a committee's work; 2) the use of structured feedback and interacting discussion—the second phase; and 3) nominal group voting for independent individual judgments—the final phase.

More specifically, the nominal group refers to a structured group process used to identify problems or to generate information concerning a topic. This structured process follows a sequence of small group activity: 1) silent generation of ideas in writing, 2) round-robin listing of ideas on flip-chart, 3) serial discussion of ideas, 4) silent listing and ranking of priorities. The sequence is critical. It is based upon social-psychological research which indicates that the procedure is clearly superior to conventional discussion groups in terms of generating higher quality, quantity, and distribution of information on fact-finding tasks. See: A. Van de Ven and A. Delbecq, "Nominal versus interacting group processes for committee decision-making effectiveness," *Academy of Management Journal*, Vol. 14, No. 2, 1971.

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\*From the Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

For a copy of the complete conference report, write to Doctor Royer at the above address.



At the third meeting, the planning committee set out to identify objectives which might move institutions toward the goal of making medical education more relevant to health care. Using the more traditional brainstorming format (the less structured, interacting group process), the committee came up with the following possible objectives:

1. Draft an action program
2. Examine innovative models (e.g. UMKC, Illinois)
3. Identify irrelevancies
4. Examine total spectrum of health education: physicians, nurses, allied health professions
5. Identify key persons (sources) to bring about change
6. Team building
7. Achieve skills:
  - interpersonal communication
  - problem-solving techniques
  - force-field analysis
8. Identify changes within our capacity (ISMA, IUSM) to effect
9. Identify major counter-forces, as well as the forces, for change
10. Identify "positives" of the system

Discussing these possible objectives, the committee agreed that three of the objectives (1, 3, 8) were both appropriate and feasible for this retreat. (It was felt that team building and skill attainment

might well come about in the process of working on the three objectives.) The committee again emphasized that the main thrust of this year's retreat should be to generate solutions to problems identified at previous retreats.

To focus attention on specific problems, the planning committee met yet a fourth time—to select and prioritize a problem list for the retreat. Using the Delbecq model, the committee brainstormed re the problems facing medical education. The specific question posed was: "What are the barriers to making medical education more relevant to health care?" Compiling the top six "barriers," three topics were drafted for the retreat:

1. How can the admissions process (college prerequisites as well as admissions criteria and selection) be made more relevant to health care?
2. What models would be desirable to make medical education more relevant to health care?
3. What changes in medical school teaching will make medical education more relevant to health care?

These, then, became the focus for retreat participants generating solutions.

### The Retreat

#### A. Opening Session

Opening session of the retreat, participants became actively in-

volved in a team-building exercise called "Lost on the Moon." This exercise is designed to illustrate, in an entertaining way, the problems and potentials of working as a group. In the exercise, each participant ranks, in order of importance, 15 items of survival equipment. Participants then form groups of 4-7 persons and are instructed to reach a consensus—a group ranking which best satisfied all group members. Individual and group rankings are then scored on the basis of the best solutions as determined by NASA experts.

The benefits of this opening exercise were several. 1) Participants immediately found themselves actively, energetically involved in the retreat. 2) Participants found that group effort is usually an improvement over its average individual response and often better than even the *best* individual response.\* 3) In contrast to the Delbecq model which followed, the random ranking of 15 survival items proved unwieldy and inefficient; a couple of groups even came to an impasse when faced with the assignment.

#### B. Workshop Sessions

Three workshop sessions comprised the bulk of the retreat. A separate session was devoted to each of the three topics chosen for the retreat, and workshop groups used the Delbecq model to brainstorm and prioritize recommendations for each of these topics. Compiled from the mass of data generated by five workshop groups are the following recommendations:

**How can the admissions process, college prerequisites as well as admission criteria and selection, be**



ONE of the student participants has a query for Dr. Steven C. Beering during the 1972 Retreat.

\*Interestingly, in *established* groups, the amount of initial agreement is critical: groups that start with great internal conflict do much better in this exercise than groups with less conflict. In other words, a wide variety of opinions is beneficial to an established group, but disruptive to an ad-hoc group.



**made more relevant to health care?**

The retreat participants recommended that the admissions process be enhanced by improving premedical counseling, to advise more liberal arts in the pre-professional curricula as well as to disseminate actual admission requirements and clear statements of both health care and medical school objectives.

It was further recommended that admission criteria include the following:

1. Formal psychological testing to determine motivation and personality;
2. Determination of the degree of correlation between premedical performance and demonstrated success in the M.D. curriculum;
3. Definition of population needs;
4. Explicit statement of interview objectives;
5. Utilization of a national matching program;
6. A clear statement of the admissions committee process.

In regard to the admissions committee itself, it was recommended that the committee include students and, perhaps, health care consumers and that the committee engage in an ongoing self-study of its policies, procedures and membership. It was recommended that the term of office of members be defined.

**What models would be desirable to make medical education more relevant to health care?**

1. It was the consensus of the retreat group that early patient exposure as well as the inclusion of a variety of educational models would be desirable. It was suggested that continuing education exercises be made a part of the undergraduate

curriculum and that identified community needs be included in the formal instructional setting.

2. Specifically, the retreat group recommended that the models include the following:

- a. Family practice department
- b. Interdisciplinary and team teaching
- c. Community based instruction—both office and hospital
- d. Continued emphasis on individual preceptorship teaching by volunteer and part-time faculty (particularly those in primary care roles)
- e. Increased emphasis on ambulatory care training
- f. Increased clinical orientation in the basic science curriculum
- g. Increased emphasis on preventive medicine and instruction in health maintenance
- h. Increased emphasis on defining the roles of allied health personnel

**What changes in medical school teaching will make medical education more relevant to health care?**

1. The retreat group recommended that the curriculum include mechanisms for ongoing revision and self-renewal, starting with explicit statement of teaching objectives, learning criteria and intended outcomes of student performance. The curriculum ideally should be oriented to problem-solving rather than fact memorization. It was further recommended that there be increasing emphasis on integrating and correlating clinical and basic science offerings. The interdisciplinary or organ-system approach, as well as small group teaching, was recommended for consideration.

2. In regard to the faculty, the retreat group recommended the

adoption of the holistic approach to the patient, the implementation of technic courses (teaching teachers to teach), the employment of selected students as teaching assistants, the appointment of larger numbers of full-time teaching faculty, as well as the identification of a better reward system for deserving teachers.

3. The group also recommended the establishment of a unit for Research in Medical Education for the development of better tools in the evaluation process. One specific recommendation voiced a need for faculty-peer review.

**C. Conclusion**

Closing session, participants were asked to evaluate the retreat. Participants generally approved of the more structured, problem-solving format. And although some persons voiced pessimism that any change would come from retreat recommendations, consensus was that the workshop sessions had been very productive.

As in previous years, participants appreciated the opportunity for dialogue among students, physicians, and faculty. The action-oriented focus seemed to facilitate the dialogue and rapprochement. That the retreat should be continued was unanimous. Consensus was that the retreat should be held annually, co-sponsored by the Indiana State Medical Association and the Indiana University School of Medicine.

To these ends—increasing esteem and trust among students, practitioners, and faculty, as well as providing a forum for problem-solving on issues of health care delivery—the student-faculty-physician retreat can continue to contribute to medical education and health care in the State of Indiana. ◀



# Medicine and the Press: Can This Marriage Be Saved?

HARRISON J. ULLMANN  
Indianapolis\*

**F**OR better and for worse, in sickness and in health, medicine and the press are wedded. And their union is a marriage of convenience and necessity which no man can put asunder.

Divorce is prevented by the citizens' overwhelming interest in their own health. The first loyalty of the news media is to the audience—the people who buy newspapers and magazines, who turn on television and radio sets, who provide a basis for the advertising which pays the costs and provides the profits of mass communications. The interests of the press reflect the interests of the audience, and that audience wants to know a lot about its health care system.

There is also a matter of accountability, both general and specific.

Much of what goes on in medicine—medical schools, hospitals, research, Medicare and Medicaid—goes on because the public provides great amounts of money for the health care system. The public is entitled to an accounting of what we are doing with its money, and the traditional vehicle for this accounting is the press.

More specifically, all the institutions of the health care system were either established by the public or established with the public's approval. If the citizens and their legislature chose to change the School of Medicine into a school for plumbers, they would have the right. Ultimately, the institutions belong to the citizens, not to us. The news media are exceptionally influential in the exercise of this ownership.

So, for better or worse and like it or not, medicine must endure the overwhelming interest of the citizens and their news media. But there are assets as well as liabilities in this.

Some of the assets are obvious. The news media have served us well by persuading citizens to contribute to hospital construction programs. Women seek inoculations for their children and Pap tests for themselves largely because of the media's persuasions. The public has allowed itself to be taxed for research, which it doesn't understand, because it has been convinced through the media that some good will come from it.

But some of the assets are more subtle and cannot be realized so long as a very considerable communications gap continues to separate the representatives of medicine from the representatives of the media. Bluntly, medicine and the media do not understand each other. There are times when they do not even seem to use the same language, other times when they seem determined to misunderstand each other.

The misunderstandings are often superficial: Scientific articles are written with the conclusions at the end; newspaper articles begin with the conclusions. The media—and the public—are not much interested in how the results were achieved if the results are reliable. The media seem scandalously imprecise to anyone trained in science, but most of us are really sufficiently informed if we know that most people do something most of the time (rather than 72% of us doing it 83% of the time) and the public does not like to read or hear a lot of numbers.

The misunderstandings which matter are much more profound, however. I think that most of us fail to realize that the reporters we encounter are not autonomous in

the pursuit of their professions in the same way that physicians, faculty members, and research scientists are autonomous in the pursuit of their professions.

Reporters work for salaries in their employment by newspapers and broadcast stations. To continue this relationship, reporters must please editors who, in turn, are keeping their jobs by attracting audiences to their newspapers or news programs. The reporter is part of a news team which he does not direct. On a newspaper, for example, someone else edits the reporter's copy, someone else writes a headline for his article, someone else determines where and how the article shall be placed in the paper. These other people are often working without consultation with the reporter and, where there is consultation, they often do what they do despite the reporter's wishes. The point to this is that reporters cannot be held exclusively responsible for what appears in the newspaper any more than physicians can be held exclusively responsible for what appears on the patient's bill.

A related difference between mass communications and professional communications is that the reporter and his employer own whatever it is that is being prepared for publication or broadcast. The author owns the material which is being prepared for publication in a journal article. The author may withdraw the manuscript, if he wishes. He has the right to approve or reject changes proposed by the editors. These same rights do not exist in mass communications.

The answers which a physician gives a reporter in the course of an interview belong to the reporter. Within the legal limits of libel laws, within the professional limits of fair-

\* Director, IUPUI News Bureau, 1100 W. Michigan St., Indianapolis, Ind. 46202.



ness and accuracy, the reporters and editors can do as they wish with those answers without any further approval from the source. A good reporter will usually check with his source to insure accuracy of difficult or technical material, but he is under no legal obligation to do this. In fact, a reporter who gives his source authority to make a final review and to give final approval without consultation with his editor may lose his job.

This makes it imperative that the source knows what is happening when he talks with a reporter. The proprietors of the health care system must never forget that reporters are coming to them for news, not for good company, and anything they tell reporters may be published or broadcast.

None of this may seem fair, and perhaps it is not. But none of us has any right to insist upon fair treatment from the world and all of us must find ways to survive and prosper despite our fates.

One of those ways is to eliminate any further contact with the press. But the health care system is an item of the public's property. If the proprietors of the system don't talk with the public through the press, both the press and the public will become uneasy and find new proprietors who will keep them informed. Further, there is no effective way to keep the press from finding out anything it really wants to know. There are no secrets, at least no big ones.

The first obligation on those who find themselves being interviewed is to make sure the reporter is fully, properly, and effectively informed. Reporters do not know as much about medicine as physicians know. The only way that reporters could have learned as much is to have gone to medical school, and then they would be physicians instead of reporters. It is reasonable to assume that the reporter is intelligent, but not that he is knowledgeable. It should not be surprising that reporters do not know much about medicine. Physicians, after all, do not know as much about publishing or broadcasting as the reporter knows.

This problem of communications between representatives of two professions with little in common presents an equal obligation to both representatives. But this should not be interpreted legalistically. It is not much comfort to a pedestrian with tire marks on his face to know that the truck driver was wrong. If the reporter commits error and nonsense in his article, the readers will assume that his source spoke the error and believe the nonsense. So, the physician has an imperative reason for ensuring that the reporter knows the subject of the interview well enough to write about it.

As the source runs through this exercise, educating the reporter, he should also keep in mind how his words will be received by the ultimate audience—those who read the article or who watch and listen to the news report. The reporter, after all, is an intermediary. He knows, and so should his subject, that the interview is being held on behalf of a much larger audience.

### Readers Enjoy Controversy

Of course, the reporter is more than an intermediary. He will be trying to get that audience's attention and then to keep it. He will do this by simplifying and emphasizing those points of the interview which are most interesting to the audience. If his source says that the point under discussion could lead to a better understanding of many disease processes, including the common cold, the article and its presentation will emphasize the possibility of a cold cure. The mass media also enjoy controversy because their readers enjoy controversy. And, incidentally, the publication of material in controversies eventually determines what the public supports, or doesn't support. If the source says that the research could contribute to a better understanding of the common cold more quickly if the National Institutes of Health were not so preoccupied with hangnails, the story will likely state that NIH is delaying the cure for the common cold. If the source does not want to seem angry with his associates, then he should avoid saying anything which might lead to a report that makes him seem angry.

There are some other factors, most having to do with time, which greatly influence what reporters and their media do.

The news media do not make news. They may bend it, slant it, misinterpret it, reinterpret it—but they do not make it. The activities of the news media are almost entirely dependent upon what goes on in the worlds they cover. If a reporter comes to a physician inquiring about leukemia, it is because something somewhere has happened with leukemia to attract the media's attention. It may be that a report has come from Washington or Boston or Berkeley about a possible cure. It may be that the Board of Health has issued some statistics which may make it seem that leukemia is more prevalent. It may be that the publisher's niece has it. But something has happened somewhere to rouse the interest of the media, and that is why the reporter has come calling. Reporters do not have idle curiosities.

One reason reporters do not have idle curiosities is that their employers won't pay them for it. Reporters are poorly paid—an established reporter may make less in most cities than a fourth-year surgery resident—but their editors consider their time to be valuable. Reporters usually are not permitted to go interviewing simply to satisfy curiosity or a yearning to learn. They are permitted by their editors to go interviewing only if there is a very good chance they will bring back something for the morning's newspaper or the evening's newscast. This means that most interviews will somehow produce something which gets published or broadcast.

And it will be published or broadcast quickly. The nature of the news media is such that only the present matters much. The rest of the week falls in the category of long-range planning; next month is in the unforeseeable future. The reason, of course, is that news is unplannable and unforeseeable. Who knows what they will be saying in Washington or Boston or Berkeley next month? Who knows what will afflict the publisher's niece next month? The urgency for news in the mass



media, the pressure of deadlines, is something that cannot be easily understood or appreciated. But it has impact. It means that the reporter does not have time to read the literature and interview other possible sources. It means he does not have time for a longer series of patients to be studied. It means he will rush into print or onto the air as soon as he has a report which seems to hang together.

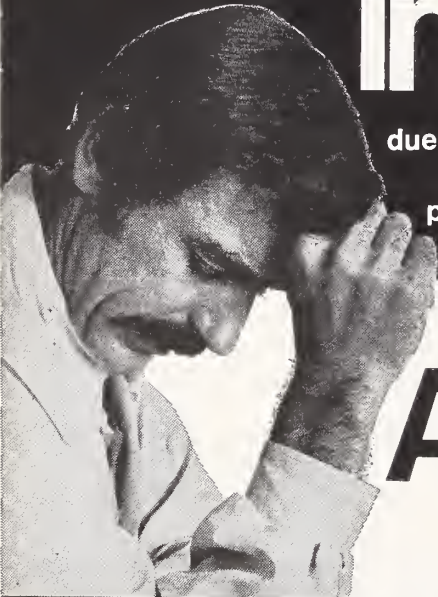
This is complicated by the reporter's personal and professional pride. This is not a mysterious element. There's an old saying that the first man to do a thing is a hero; the last is a fool. The cliché is as true of medicine as it is of journalism—medicine's accolades and gold medals go to the physicians who manage to do something first, without killing too many of the patients, rather than to the man who finally

discovers how to do it best. Accolades and gold medals in journalism go to the reporters who get the news first, without too many mistakes, rather than to the reporter who finally writes the definitive story.

The thrust of this article places rather more pressure on medicine than on the press. There are good reasons for the apparent unfairness. The audience for this article is medicine, rather than media, and it does the quality of mass communications little good to tell physicians what reporters ought to do, or reporters what the physicians should be doing. A more compelling reason for the emphasis is that matter of error. The truly damaging errors which are published or broadcast are errors of interpretation or of emphasis, and the ingredients of these errors are debatable matters of judgment. For a variety of rea-

sons, all of them either human or monetary, the media are unwilling to admit error unless it is undeniably self-evident. And even when the media admit error, few of the audience will notice the retraction or correction.

It is not fair—few marriages operate on any basis of fairness—but medicine is hurt more by error in mass communication than are the news media. Since the attention of the media is unavoidable, the managers and operators of the health care system had best learn how to use the media effectively and responsibly so that the citizens are persuaded to keep all of us in our jobs. It may sound unbelievable to a physician who has just looked at his appointment calendar, but we need the public worse than it thinks it needs us. ◀



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References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titoff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. J. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:931, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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# *Physicians, Nurses, Others Attend Institute on Drugs*

Medical and other scientific experts from throughout the nation spoke at the Drug Training Institute for Indiana physicians, July 12 and 13 at Stouffer's Indianapolis Inn.

More than 130 physicians, nurses and allied health personnel working in drug programs throughout Indiana attended the program which was jointly sponsored by the Indiana State Medical Association, Pfizer Pharmaceuticals, Inc., the Indiana Academy of Family Physicians, Department of Psychiatry and the Division of Postgraduate Medical Education, Indiana University and the State Department of Mental Health.

Hanus J. Grosz, M.D., professor of psychiatry, Indiana University School of Medicine, and chairman of the ISMA Commission on Special Activities presided.

Speakers on the program included Donald B. Louria, M.D., Newark, N.J., professor and chairman, De-

partment of Preventive Medicine and Community Health, New Jersey Medical School. His subject was "Medical Complications of Drug Abuse."

"General Pharmacology of Those Drugs Subject to Abuse" was discussed by Melvin H. Weinswig, Ph.D., Madison, Wis., associate dean, School of Pharmacy, University of Wisconsin.

David E. Smith, M.D. spoke on "Goofballs, Smack, Grass, Speed, Snow, Acid, and Angel Dust."

Doctor Smith is founder and director, Haight-Ashbury Free Medical Clinic, San Francisco, and assistant clinical professor of toxicology, University of California Medical Center, San Francisco.

Robert B. Forney, Ph.D., Indianapolis, professor of toxicology, Indiana University School of Medicine, and director, State Department of Toxicology, spoke on

"Alcohol—Drug Interactions."

"The Drug Scene—1972" was discussed by J. Thomas Ungerleider, M.D., Los Angeles. Doctor Ungerleider is associate professor of psychiatry, Neuropsychiatric Institute, University of California.

Other speakers included G. G. DeAngelis, Ph.D., associate director in the Special Action Office for Drug Abuse Prevention, Washington, D.C., "Treatment of the Adolescent—The Program at Vitam Center;" Beny J. Primm, M.D., Brooklyn, N.Y., program director, Addiction Research and Treatment Corporation, "The Doctor's Role in Drug Abuse: Community Action Programs and Some Reflections on Methadone;" and K. Edwin Applegate, J.D., Bloomington, former United States Attorney, Southern District of Indiana, "Medical-Legal Implications of Drug Abuse for the Physician."





# Would You?

**W**OULD you like to join a medical organization, one based on a free and absolutely representative government? One that is open to any competent and ethical physician? That is available in every state and nearly every country? That is concerned as much as its members permit in policing the ethics of medicine?

Would you?

Would you like to belong to a professional organization that is involved in attempting to bring solutions to every problem in the medical area of society, having first made sure it is a problem? An organization that gives you a floor for your opinions and representation in the development of policy from the country up to and through the states to the nation? One that studies hard and works hard to represent all segments of medicine? And still has to see to the problems and solutions of all of the people outside of medicine? And recognizes that it must do what individuals and small groups cannot do?

Would you?

Would you believe that other doctors care—and really care enough about you and your opinions and your problems and your proposals to carry the ball all of the way to the national newspapers, television,

and even the floor of the national legislative halls? Because you don't have the time or don't take the time or just don't care?

Would you?

Do you want to belong to a professional organization that sets the standards of professional care and that now establishes the means to audit and assure the standards of medical care delivered to the American people? All of the American people? An organization that establishes and approves standards of education for MD degrees, standards for surgeons, internists, orthopedists, and family practitioners and still protects the rights of all?

Do you?

Would you like to join a medical organization to whom the President, senators, members of Congress, governors, mayors, Jane Smith and Jimmy Jones and the editors of all newspapers come for advice and help on medical matters from a stumped toe to insurance and medical care for all people?

Would you?

Would you like to be part of a 124-year-old scientific organization that has been the greatest single impetus to scientific progress in medicine since its inception? And which today is more active in helping to discover the answers for the scientific problems of medicine and

of getting it to doctors than all other organizations in the world?

Would you?

If you have never joined you have a stake like the rest of us. Just pay the pittance of dues, roll up your sleeves, and jump into work. You too, can be involved in the development of the next 30 years—the greatest years, potentially, in the history of this beautiful planet we have tried to destroy. And medicine will offer the greatest drama of all, and some of the most important and magnificent drama in all of human endeavor. And the AMA is the most important organization in the relation of medicine to society, government, business, and all other facets of human endeavor. And the state and county societies must provide the base from which it operates and from which ideas come. We all have a stake in a great future. Where we will go we do not know. But we dare not “sulk in our tents.” We must be a part of all that happens. Our strength is the greatest medical organization in the world and in the doctors that have the courage and strength and compassion to make it great for all people.—**John H. Saf-fold, M.D., immediate past president, Tennessee Medical Ass'n, in the TMA Journal, Dec. 1971. Reprinted with permission.**

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## To the Physicians of Indiana:

Due to the lack of extra help, the registration receipts for the 1972-74 registration will be late in being processed and forwarded. Please bear with us.

JOSEPH D. O'BRIEN  
Administrator, Indiana Board  
of Medical Registration and  
Examination



123rd  
Annual Convention

# INDIANA STATE MEDICAL ASSOCIATION

October 14, 15, 16, 17 and 18, 1972

*All Events on Eastern Standard Time*

*New Convention-Exposition Center*

*Indianapolis*

*Complete Program and  
Annual Reports on  
Following Pages*



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# Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Indiana Convention-Exposition Center, Indianapolis, Indiana, October 15, 16, 17 and 18, 1972.

The House of Delegates will be constituted as follows: Marion County, twenty-one delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, Owen-Monroe and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other fifty-six county societies, each one delegate; fourteen trustees and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Wm. Harry Howard, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen and Malcolm O. Scamahorn, and ex-officio, the president, president-elect, the executive secretary, the treasurer and assistant treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote. Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power to vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 2:00 p.m., EST, Sunday, October 15, 1972, in the Indiana Convention-Exposition Center and again at 9:00 a.m., EST, Tuesday, October 17, 1972. The final meeting of the House of Delegates for the election of officers will be held at 9:00 a.m., EST, Wednesday, October 18, 1972, in the Indiana Convention-Exposition Center.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1971 session.
6. Reading of the minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of the president-elect.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of *Journal* editor.
20. Report of AMA delegates.

21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions.

## COMMITTEES

- (1) Executive
- (2) Grievance
- (3) Student Loan
- (4) Medical-Legal Review
- (5) Future Planning
- (6) Sports and Medicine
- (7) Medicine and Religion

## COMMISSIONS

- (1) Convention Arrangements
  - (2) Constitution and Bylaws
  - (3) Legislation
  - (4) Public Information
  - (5) Governmental Medical Services
  - (6) Public Health
  - (7) Voluntary Health Agencies
  - (8) Inter-Professional Relations
  - (9) Medical Economics and Insurance
  - (10) Medical Education and Licensure
  - (11) Special Activities
  - (12) Aging
  - (13) Emergency Medical Services
  - (14) Specialty Medicine
23. New Business:
- (1) Matters referred by the Board of Trustees
  - (2) Matters referred by the Executive Committee
  - (3) Resolutions
  - (4) Selection of city for 1977 meeting.  
1973 - Indianapolis - October 6 - 11  
1974 - Indianapolis - October 5 - 10  
1975 - Indianapolis - October 11 - 16  
1976 - Indianapolis - October 9 - 14

The election of officers will be first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1972, and their successors must be elected at the session: delegates to the American Medical Association to succeed James A. Harshman, Kokomo; Eugene F. Senseny and Frank H. Green, Rushville; alternate delegates to succeed A. Alan Fischer, Indianapolis; Eugene S. Rifner, Van Buren; and Kenneth O. Neumann, Lafayette.

Delegates from the Second, Fifth, Seventh, Eighth and Eleventh Districts are reminded that the terms of their trustees will expire October 18, 1972, and new trustees should be elected to succeed the following:

- Second—Joe Dukes, Dugger  
Fifth—Wilbert McIntosh, Riley  
Seventh—Dwight W. Schuster, Indianapolis  
Eighth—Richard G. Ingram, Montpelier  
Eleventh—Lowell Hillis, Logansport

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, Executive Secretary.



# HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 15, 16, 17 and 18, 1972

County and Delegates	Alternates	County and Delegates	Alternates
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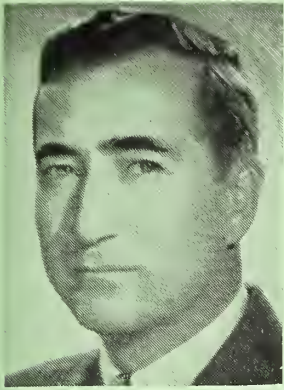
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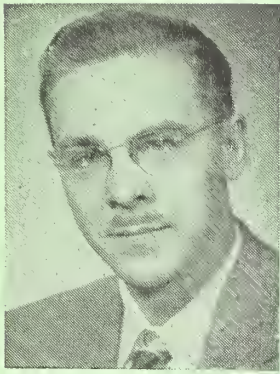


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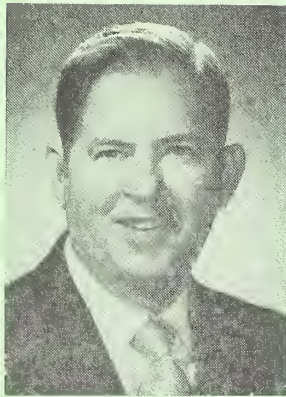




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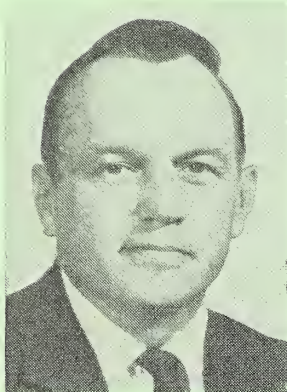
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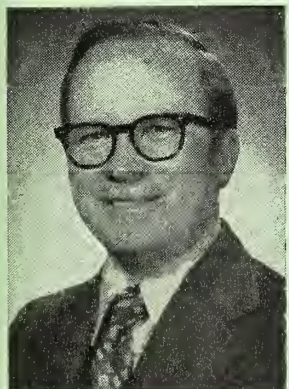
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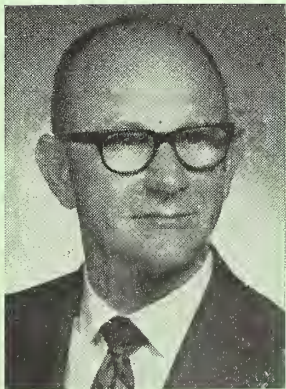
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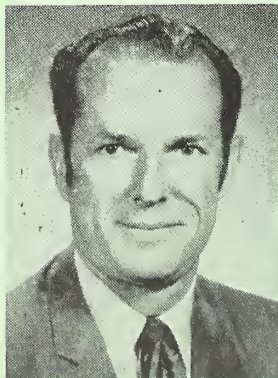
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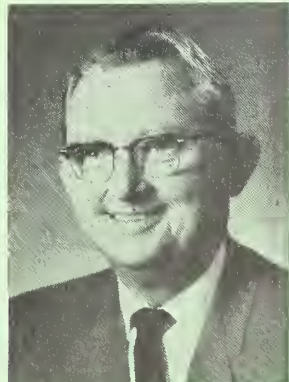
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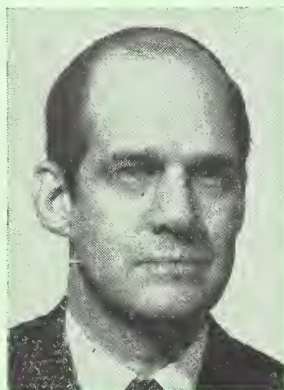
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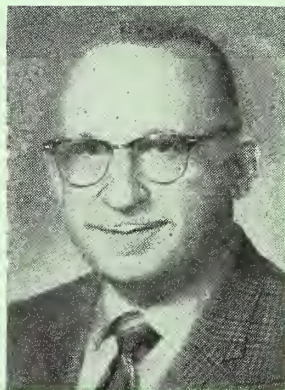
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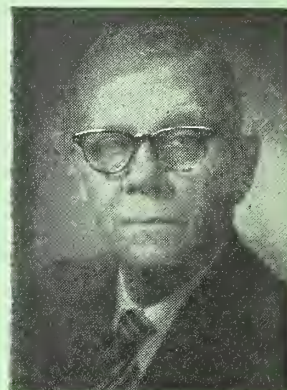
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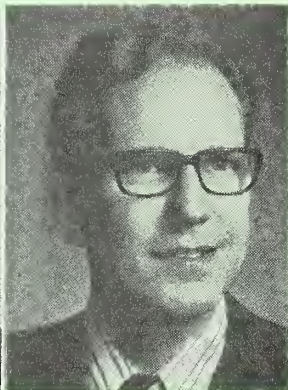
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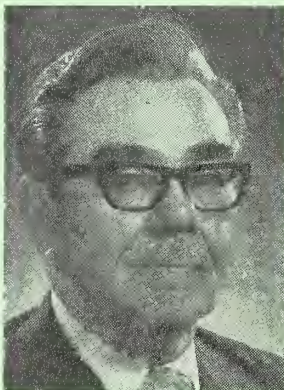
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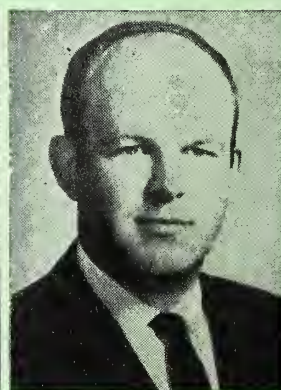
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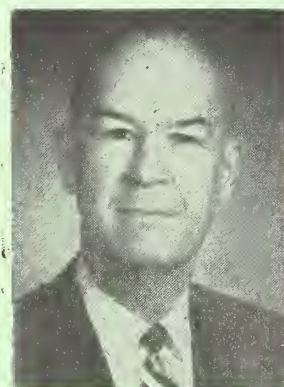
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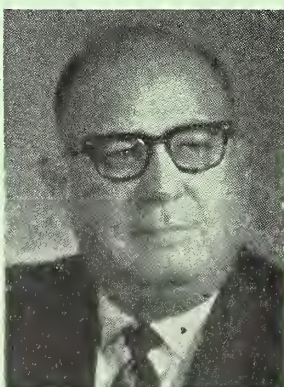
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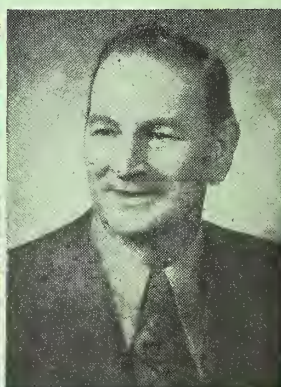
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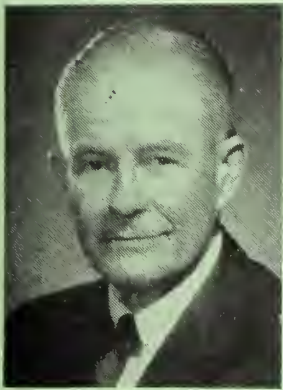
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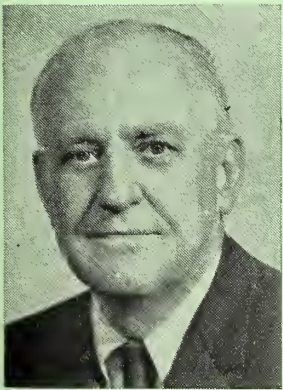
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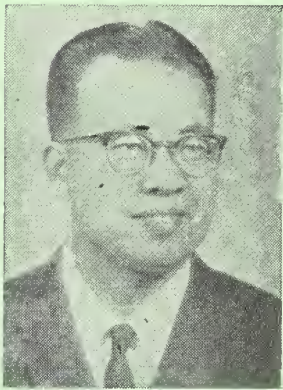
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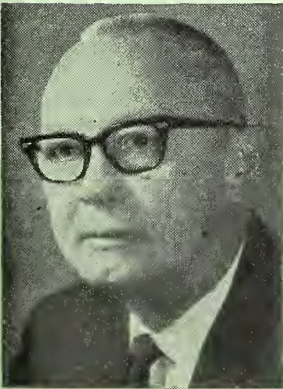
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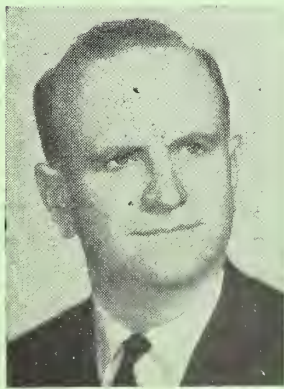
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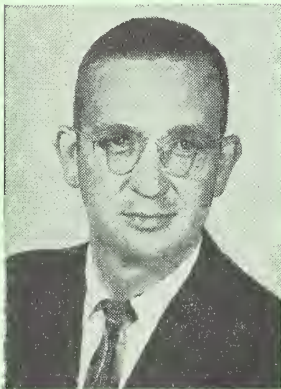
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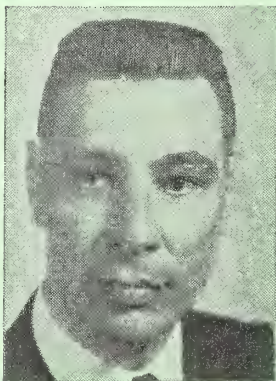
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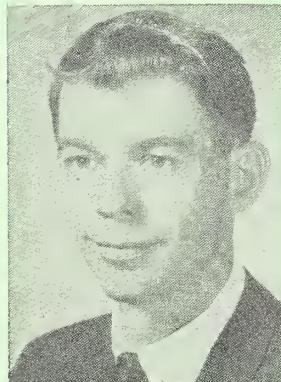


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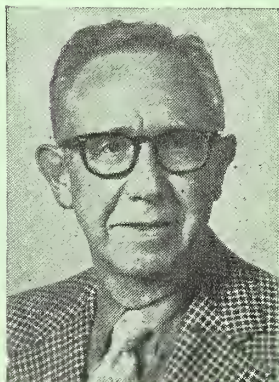


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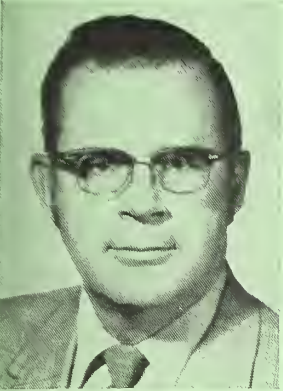


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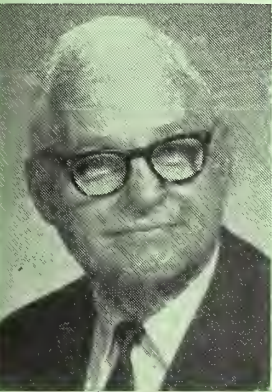
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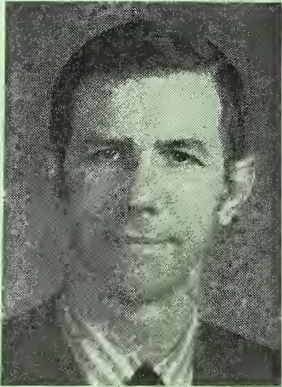
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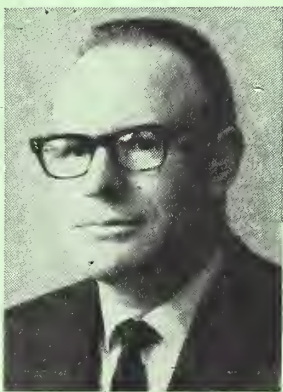
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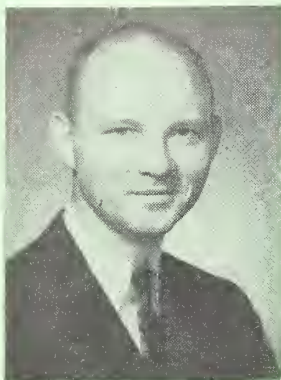
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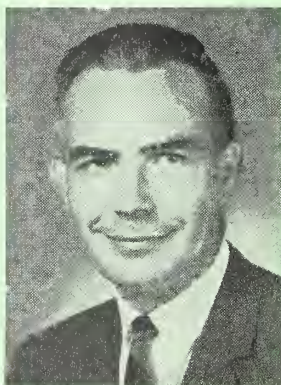


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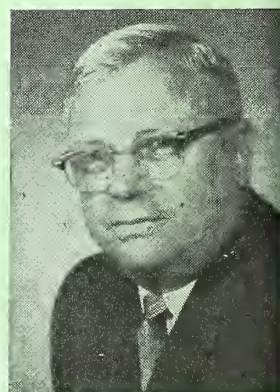


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**WOMEN PHYSICIANS:** Glen McClure, Sullivan, chairman.

**GOLF TOURNAMENT:** Joseph E. Ball, Indianapolis, chairman.

**AUXILIARY and WOMEN'S ACTIVITIES:** Mrs. Richard B. Schnute, Indianapolis, general chairman.

**ART and HOBBY SHOW:** Mrs. Harry Siderys and Mrs. Harold G. Halbrook, Indianapolis, co-chairmen.



# Schedule of Events

123rd Annual Convention  
Indiana Convention-Exposition Center  
100 S. Capitol Avenue  
Indianapolis, Indiana

*(All Events on Eastern Standard Time)*

*(All Events will be in the Indiana Convention-Exposition Center)*

*(The scientific program for the 123rd annual convention of the Indiana State Medical Association is acceptable for three Elective and eight Prescribed accredited hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the General Practice Section meeting.)*

## Saturday, October 14, 1972

- 9:00 a.m. Executive Committee meeting, Room 225
- 12 Noon Board of Trustees, luncheon meeting, Room 226
- 8:00 p.m. Annual Board of Trustees dinner, Ballroom, Hilton Hotel
- 10:00 p.m. Dancing

## Sunday, October 15, 1972

- 9:00 a.m. Board of Trustees, breakfast meeting, Room 226
- 2:00 p.m. Meeting of House of Delegates, Room 210 (Nomination of Officers)
- 7:00 p.m. Reference Committee meetings  
Reference Committee No. 1, Room 104  
Reference Committee No. 2, Room 105  
Reference Committee No. 3, Room 106  
Reference Committee No. 4, Room 107  
Reference Committee No. 5, Room 108

## Monday, October 16, 1972

- 8:00 a.m. Board of Trustees, breakfast meeting, Room 226
- 8:30 a.m. Registration begins, Concourse
- 9:00 a.m. Opening of technical and scientific exhibits, Hall C
- 11:00 a.m. Golf Tournament, Speedway Golf Course, 4400 West 16th Street
- 1:00 p.m. Meeting of Small County Delegates, Room 104

- 1:00 p.m. Scientific Motion Picture Program, Room 224
- 5:00 p.m.

### Partial List of Films to Be Shown

- "Cardiac Arrest" — Bruce C. Paton, M.D.
- "Secretion of Insulin" — Paul E. Lacy, M.D.
- "Treatment of Acute Drug Overdose" — G. R. Gay, M.D.
- "Aspiration Abortion Without Cervical Dilatation" — A. J. Margolis, M.D.
- "Patient Care and Understanding" — J. K. Lattimer, M.D.
- "Female Pelvic Viscera" — L. E. Wragg, M.D.

- 1:00 p.m. Guided Tour of the City (Stop at Speedway) Buses will leave from and return to Indiana Convention-Exposition Center
- 4:00 p.m.

- 5:30 p.m. Cocktail Party, Reception Room (Courtesy of the Seventh District Medical Society)

- 7:00 p.m. Women Physicians, dinner, Room 226
- 8:30 p.m. Program on "ACUPUNCTURE" presented by Wei-Ping Loh, M.D., Gary, Room 210  
(Members and guests invited to attend program which is sponsored by the Women Physicians of the Indiana State Medical Association.)



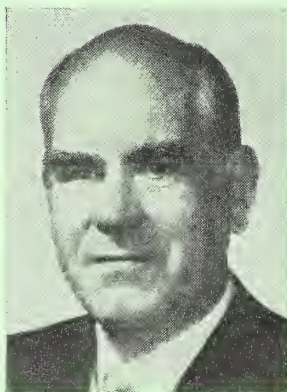
## SPEAKERS



**HOWARD R. MARVEL, M.D.**  
Lafayette  
Diplomate, American Board of Internal Medicine; on staffs of St. Elizabeth and Lafayette Home Hospitals; M.D. degree from University of Michigan in 1948 with internship and residency at Henry Ford Hospital.  
Chairman, Commission on Convention Arrangements

**RUSSELL B. ROTH, M.D.**  
Erie, Pa.

President-elect, American Medical Association; attending urologist at St. Vincent's and Veterans Administration Hospitals in Erie; Fellow of American College of Surgeons; former member of Surgeon General's Advisory Committee and a member of the Dependents Medical Care Advisory Committee. Received M.D. degree from Johns Hopkins University.



### THE EXHIBITS

We urge you to visit with the exhibitors — they are here to help you — and to bring you the latest information. They contribute to financing your convention.

## Tuesday, October 17, 1972

- 8:00 a.m. Board of Trustees, breakfast meeting, Room 226
- 8:30 a.m. Registration continues, Concourse
- 8:30 a.m. Opening of technical and scientific exhibits, Hall C
- 9:00 a.m. Meeting of House of Delegates, Room 210 (Time allowed to view technical and scientific exhibits, Hall C)
- 9:00 a.m. Scientific Motion Picture Program, Room 224  
to
- 12 Noon
- 12 Noon Editorial Board, luncheon meeting, Room 225
- 12 Noon Past Presidents' Luncheon, Room 218

### GENERAL MEETING

Room 210

(Women are invited and urged to attend this meeting)

- 2:00 p.m. Call to order by Peter R. Petrich, M.D., ISMA president  
to
- 4:00 p.m.

### HEALTH CARE DELIVERY IN U.S. — "WHO, WHAT, WHERE and HOW MUCH?"

Moderator: Peter R. Petrich, M.D.

Panel: **Congressman Jerry L. Pettis (R) California**

**Congressman Peter N. Kyros (D) Maine**

**Russell B. Roth, M.D., Erie, Pennsylvania, President-elect, American Medical Association.**

- 6:00 p.m. President's Reception and Reception for Fifty Year Club, Reception Room
- 7:00 p.m. President's Dinner, Ballroom  
Presiding Officer: Peter R. Petrich, President, Indiana State Medical Association  
Invocation  
Recognition of Fifty-Year Club  
Response: David H. Sluss, M.D., Indianapolis  
Presentation of Mental Health Award  
Presentation of Public Relations Awards  
Presentation of Community Service Award  
Presentation of Scientific Awards



**Wednesday, October 18, 1972**

- 8:00 a.m. Board of Trustees breakfast meeting,  
Room 226
- 8:30 a.m. Registration continues, Concourse
- 8:30 a.m. Opening of technical and scientific ex-  
hibits, Hall C
- 9:00 a.m. Final meeting of House of Delegates  
(Election of Officers), Room 210  
Meeting of Board of Trustees and Execu-  
tive Committee immediately after ad-  
journing of House of Delegates  
Time allowed to view technical and  
scientific exhibits, Hall C

**Section and Specialty Meetings**

**12 Noon SECTION ON ANESTHESIOLOGY  
and INDIANA SOCIETY OF ANES-  
THESIOLOGISTS**

Luncheon meeting, Room 225  
Film on "ACUPUNCTURE AND  
ELECTRICAL ACUPUNCTURE"  
Remarks by Wei-Ping Loh, M.D., Gary

**9:30 a.m. SECTION ON CUTANEOUS  
MEDICINE**

Marion County General Hospital, Derma-  
tology Clinic (No. 6), 960 Locke Street,  
Indianapolis  
Review of Clinical Cases

10:30 a.m. Discussion of Clinical Cases

11:30 a.m. "THERAPEUTIC CONSIDERA-  
to TIONS,"

11:40 a.m. Jere Guin, M.D., Kokomo

11:40 a.m. "GRISEOFULVIN, ACTIONS AND  
to REACTIONS,"

11:50 a.m. William B. Moores, M.D., Indianapolis

11:50 a.m. "INTRANUCLEAR INCLUSIONS IN  
to PSORIASIS,"

12 Noon Warren W. Epinette, M.D., Indianapolis

12:00 Noon "CHEMOSURGERY FOR RECUR-  
to RENT AND INVASIVE CANCER OF  
12:30 p.m. THE SKIN,"

Barry A. Goldsmith, M.D., Chicago

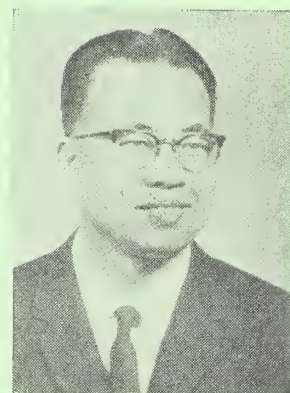
12:30 p.m. Luncheon  
Election of Section Officers for 1973

**SECTION ON GENERAL PRACTICE,  
Room 201**

9:00 a.m. "THE PROBLEM ORIENTED REC-  
ORD IN A FAMILY PRACTICE  
SETTING,"

Ronald G. Blankenbaker, M.D., India-  
napolis

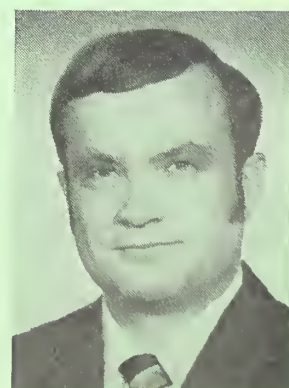
**SPEAKERS**



**WEI-PING LOH, M.D.**

**Gary**

Pathologist and part-time clinical as-  
sociate professor at the Chicago Medi-  
cal School; M.D. degree from Yale-  
in-China Medical School with intern-  
ships in China and Boston.

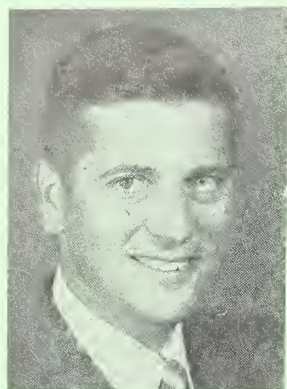


**RONALD G. BLANKENBAKER, M.D.**  
**Indianapolis**

Director of Family Practice Education,  
Methodist Hospital, and director of  
Family Practice Center, 155 West 16th  
St.; M.D. degree from Indiana Univer-  
sity School of Medicine 1968.



## SPEAKERS



**JACK H. HALL, M.D.**

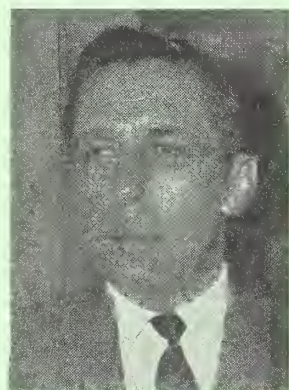
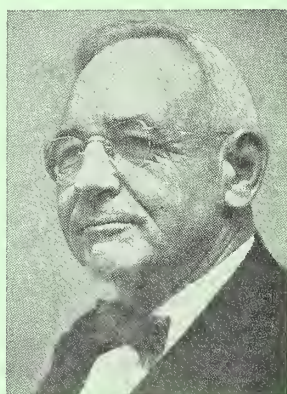
Indianapolis

Director of Medical Education, Methodist Hospital Graduate Medical Center and assistant dean, Indiana University School of Medicine; M.D. degree, Indiana University School of Medicine in 1956.

**JOHN S. MILLIS, Ph.D.**

Cleveland, Ohio

President, National Fund for Medical Education; former president of Western Reserve University and chancellor of Case Western Reserve University.



**A. ALAN FISCHER, M.D.**

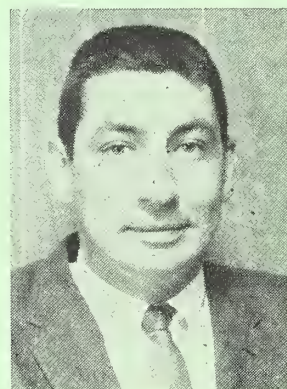
Indianapolis

Director, Family Practice Program, Indiana University School of Medicine; vice president, American Academy of Family Practice; M.D. degree from I.U. School of Medicine in 1952.

**ROSS L. EGGER, M.D.**

Daleville

Director of Family Practice Residency, Ball Memorial Hospital, Muncie; diplomate of the American Board of Family Practice; regional adviser, Education Commission of the AAGP; member, Advisory Committee for Continuing Medical Education and Physician Recognition Award Committee, AMA; M.D. degree from Indiana University School of Medicine, 1962.



**JERRY A. ROYER, M.D.**

Indianapolis

Assistant professor of Postgraduate Medicine, Indiana University School of Medicine; consultant, Task Force on Drug-Related Studies (HEW: National Center for Health Services Research and Development) M.D. degree from I.U. School of Medicine 1969.

- 10:00 a.m. "HOW TO PROTECT YOURSELF FROM STATISTICIANS,"  
Harvey Geller, Bethesda, Maryland
- 11:00 a.m. "PROSPECTIVE MEDICINE,"  
Jack H. Hall, M.D., Indianapolis
- 12 Noon Combined luncheon with Section on Directors of Medical Education and the Association of Indiana Directors of Medical Education, Room 203
- "RELATING THE WORLD OF MEDICAL CARE TO THE WORLD OF MEDICAL EDUCATION,"  
John S. Millis, Ph. D., Cleveland, Ohio
- 1:30 p.m. Business meeting of Section on General Practice, Room 201  
Election of Section Officers for 1973
- 2:00 p.m. "PROGRESS REPORT ON DEPARTMENT OF FAMILY PRACTICE, INDIANA UNIVERSITY SCHOOL OF MEDICINE,"  
A. Alan Fischer, M.D., Indianapolis
- 2:30 p.m. "THE RESULTS OF RETREAT SPONSORED BY I. U. MEDICAL SCHOOL AND ISMA COMMISSION ON MEDICAL EDUCATION and LICENSURE,"  
Ross L. Egger, M.D., Daleville and Jerry A. Royer, M.D., Indianapolis



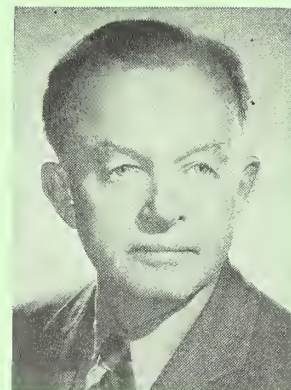
## SPEAKERS

3:30 p.m. "HEALTH HAZARD APPRAISAL,  
THE PRINCIPAL TOOL OF PROS-  
PECTIVE MEDICINE,"

Lewis C. Robbins, M.D., Indianapolis

**LEWIS C. ROBBINS, M.D.**  
Indianapolis

Chief, Health Hazard Appraisal De-  
partment, Methodist Hospital; recipient  
of Distinguished Public Services Award  
and the Commendation Medal, Public  
Health Service; diplomate, American  
Board of Preventive Medicine; M.D.  
degree Indiana University School of  
Medicine 1935.



## INDIANA PHILIPPINE MEDICAL ASSOCIATION, ROOM 224

### Clinical Conference

9:30 a.m. "GASTRIC BY-PASS FOR INTRACT-  
ABLE OBESITY,"

Clemente F. Oca, M.D., Jeffersonville

"RADIONUCLID ANGIOGRAPHIC  
STUDY IN THE DETECTION OF  
CONGENITAL CARDIAC CONDI-  
TIONS,"

Miguel Dizon, M.D., Indianapolis

"NEUROSURGICAL MANAGEMENT  
OF ACUTE HEAD INJURIES,"

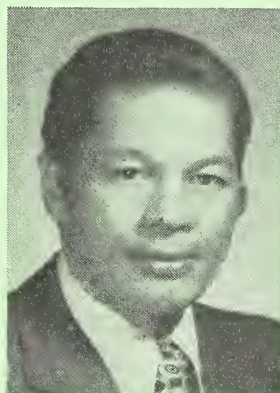
Antonio Doneso, M.D., Fort Wayne

"ACTIVITIES OF THE MEDICAL  
MISSIONS, INCORPORATED,"

Jesus C. Bacala, M.D., Scottsburg

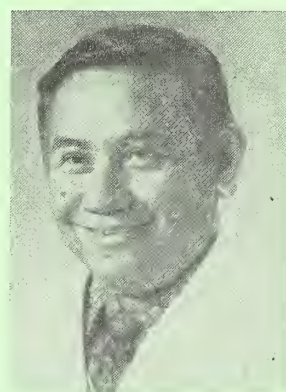
"BUBBLE FILM OXYGENATOR,"

Jose Torres, M.D., Jeffersonville



**CLEMENTE OCA, M.D.**  
Jeffersonville

General and chest surgery; vice presi-  
dent for Southern Indiana, Indiana  
Philippine Medical Association; M.D.  
degree from University of Santo  
Tomas, Manila, 1950.



**MIGUEL B. DIZON, M.D.**  
Indianapolis

Assistant professor of radiology and  
nuclear medicine, Indiana University  
School of Medicine; Fellow of Ameri-  
can Society of Nuclear Medicine; gen-  
eral secretary, Indiana Philippine  
Medical Ass'n.

12 Noon Luncheon, Room 212

2:30 p.m. SYMPOSIUM ON PROFESSIONAL  
CORPORATIONS IN MEDICAL  
PRACTICE

"THE LEGAL ASPECTS of MEDICAL  
INCORPORATION,"

George P. Adinamis, B.Sc., J.D., India-  
napolis

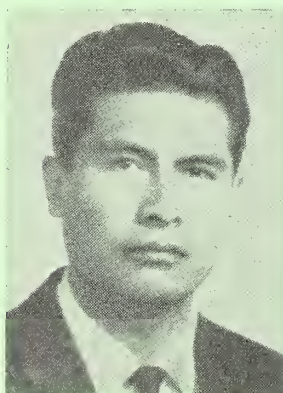
"ACCOUNTING ASPECTS of PRO-  
FESSIONAL CORPORATIONS,"

Paul Evans, Indianapolis

Open Forum-Moderator: Jesus C. Bacala,  
M.D., Scottsburg

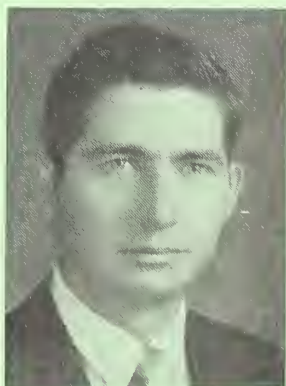
Business Meeting-Efren Ramirez, M.D.,  
Indianapolis, Presiding

Preparations for the Inaugural Cere-  
monies at Brazil, Indiana



**JOSE TORRES, M.D.**  
Jeffersonville

Chest and general surgery; inventor  
of the Bubble Film Oxygenator. M.D.  
degree from San Marcos University,  
Lima, Peru, 1954.



**GEORGE P. ADINAMIS, J.D.**  
Indianapolis

Attorney; Former special agent, U.S.  
Treasury, Chicago; served in office of  
Chief Counsel, I.R.S. at Philadelphia  
and Indianapolis; graduate of John  
Marshall Law School.



## SPEAKERS



**WILLIAM A. SODEMAN, M.D.**  
Philadelphia  
Dean emeritus and professor of medicine emeritus, Jefferson Medical College; president, American College of Physicians 1972-73; past president, American College of Cardiology; consultant, U. S. Naval Hospital, Department of HEW, Social Security Administration; M.D. degree from University of Michigan in 1931.

**WILLIAM C. FELCH, M.D.**  
Rye, N.Y.  
Trustee, New York Medical College; president-elect, American Society of Internal Medicine; member AMA section Council on Internal Medicine; chairman, Intersociety Committee on Multiphasic Health Screening. M.D. degree from Columbia College of Physicians and Surgeons 1945.



**EDWARD W. HOOK, M.D.**  
Charlottesville, Va.  
Professor and chairman, Department of Medicine, University of Virginia School of Medicine; editor, Antimicrobial Agents and Chemotherapy; physician-in-chief, University of Virginia Hospital; M.D. degree from Emory University School of Medicine in 1949.

**SECTION ON INTERNAL MEDICINE, INDIANA SOCIETY OF INTERNAL MEDICINE, AND INDIANA CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS. THE HEALTH PROFESSIONS BRANCH OF THE CENTER FOR DISEASE CONTROL, Atlanta, Ga., is co-sponsor of the following program: (Room 107)**

- 9:00 a.m. Welcome and Introductory Remarks  
to
- 9:15 a.m. "MODES OF ACTION OF ANTIBIOTICS: THEIR CLINICAL USE AND ABUSE,"  
to
- 10:15 a.m. Ward E. Bullock, M.D., Lexington, Ky.
- 10:15 a.m. Coffee Break  
to
- 10:30 a.m. "ANAEROBIC INFECTIONS: WHAT IT IS, HOW TO PROVE IT, WHAT TO DO ABOUT IT,"  
to
- 11:30 a.m. Walter S. Wood, M.D., Maywood, Ill.
- 11:30 a.m. Luncheon and Business Meeting, Ballroom  
to
- 2:00 p.m. "ACTIVITIES OF AMERICAN COLLEGE OF PHYSICIANS AND AMERICAN SOCIETY OF INTERNAL MEDICINE,"  
to
- 1:00 p.m. "WHAT'S NEW IN THE AMERICAN COLLEGE OF PHYSICIANS?"  
to
- 1:25 p.m. William A. Sodeman, M.D., Philadelphia, Pa., President, American College of Physicians
- 1:30 p.m. "WHAT'S NEW IN THE AMERICAN SOCIETY OF INTERNAL MEDICINE?"  
to
- 1:55 p.m. William C. Felch, M.D., Rye, N.Y., President, American Society of Internal Medicine  
Election of Section Officers for 1973
- 2:00 p.m. "PROPHYLACTIC ANTIBIOTICS: WISDOM or FOLLY?"  
to
- 3:00 p.m. Edward W. Hook, M.D., Charlottesville, Va.
- 3:00 p.m. Coffee Break  
to
- 3:15 p.m. "THE NEWER ANTIBIOTICS AND GRAM NEGATIVE INFECTIONS,"  
to
- 4:15 p.m. Speaker to be announced.



**SECTION ON DIRECTORS OF MEDICAL EDUCATION AND ASSOCIATION OF INDIANA DIRECTORS OF MEDICAL EDUCATION, Room 104**

10:30 a.m. "THE DIRECTOR OF MEDICAL EDUCATION AS AN ADMINISTRATOR,"

John S. Millis, Ph.D., Cleveland  
Business Meeting—Election of Section Officers for 1973

12 Noon Combined luncheon with Section on General Practice, Room 203

"RELATING THE WORLD OF MEDICAL CARE TO THE WORLD OF MEDICAL EDUCATION,"

John S. Millis, Ph.D., Cleveland

**SECTION ON OBSTETRICS AND GYNECOLOGY AND INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Room 106**

9:00 a.m. Introduction — Frank C. Donaldson, M.D., Anderson, President, Indiana Obstetrical and Gynecological Society

9:15 a.m. "INHIBITION OF LABOR: PREMATURITY AND TERM,"

10:00 a.m. Tom P. Barden, M.D., Cincinnati

10:00 a.m. Coffee Break

10:15 a.m. "MANAGEMENT OF THE RH IMMUNIZED PREGNANCY,"

11:00 a.m. John T. Queenan, M.D., Louisville, Ky.

11:00 a.m. Panel Discussion

to Participants: Tom P. Barden, M.D.  
11:45 a.m. John T. Queenan, M.D.  
and  
Moderator

12 Noon Luncheon, Room 124

1:00 p.m. "PRESENT STATUS OF CLINICAL FETAL MONITORING,"

1:45 p.m. Tom P. Barden, M.D., Cincinnati

1:45 p.m. Coffee Break

2:00 p.m. "CARE OF THE DIABETIC PATIENT IN PREGNANCY,"

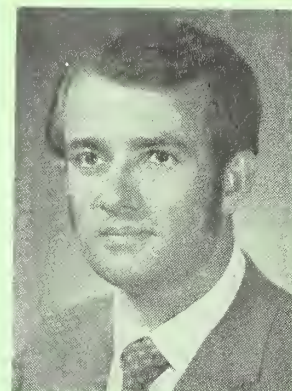
2:45 p.m. John T. Queenan, M.D., Louisville, Ky.

2:45 p.m. Panel Discussion

to Participants: Tom P. Barden, M.D.  
3:30 p.m. John T. Queenan, M.D.  
and  
Moderator

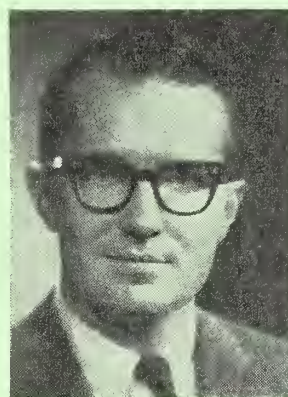
3:30 p.m. Business Meeting  
Election of Section Officers for 1973

**SPEAKERS**



**TOM P. BARDEN, M.D.**  
Cincinnati

Associate professor of pediatrics, obstetrics and gynecology, University of Cincinnati College of Medicine; Fellow of American College of Obstetricians and Gynecologists; M.D. degree from Indiana University School of Medicine 1958.



**JOHN THOMAS QUEENAN, M.D.**  
Louisville, Ky.

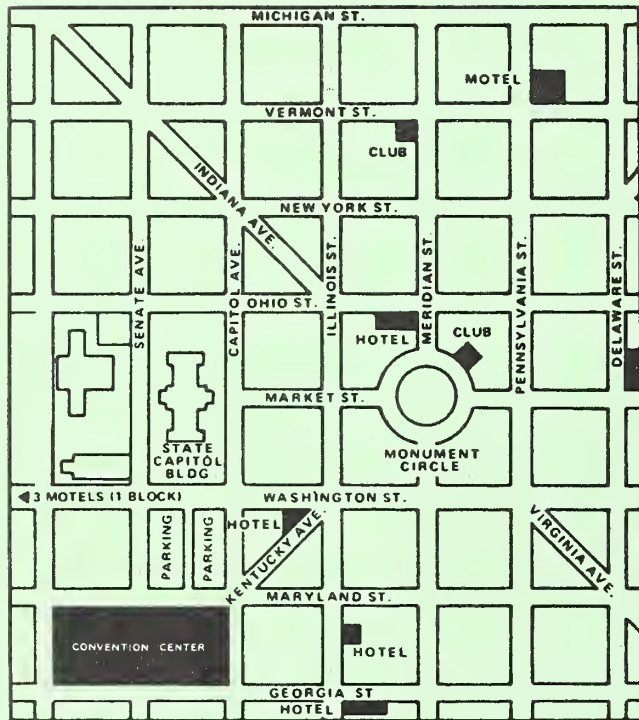
Professor and chairman, Department of Obstetrics and Gynecology, University of Louisville; diplomate of the National Board of Medical Examiners and of the American Board of Obstetrics and Gynecologists; Fellow of the American College of Surgeons and American College of OB-GYN; M.D. degree from Cornell University 1954.

**Telephone Service**

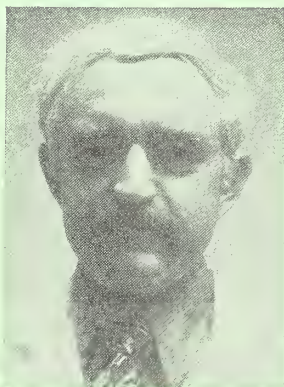
Special telephone lines will be installed at the convention again this year. You will be paged if you have your office call you at (317) 634-6662.



## SPEAKERS



Downtown Indianapolis  
Showing Convention Center



**NED B. HORNBACK**  
Indianapolis

Chairman, department of radiation therapy, Indiana University School of Medicine; consultant in radiation therapy of West Tenth St. Veterans Administration Hospital and Marion County General Hospital. M.D. degree from University of Wisconsin 1956.

12 Noon

## SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH AND INDIANA ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, INC.

Luncheon, Room 226

Presiding: James S. Robertson, M.D., Plymouth, President, Indiana Association of Public Health Physicians, Inc.

Panel: RURAL AND SUBURBAN WASTEWATER DISPOSAL

Moderator: Robert W. Heider, Indianapolis, Director, Division of Sanitary Engineering, Indiana State Board of Health

Participants: Victor G. Wagner, P.E., Consulting Engineer, Henry B. Steeg and Associates, Indianapolis

Robert R. Mefford, Administrator, Porter County Health Department, Valparaiso

Wayne E. Rafferty, Planner, Southwestern Indiana-Kentucky Regional Council of Governments, Evansville  
Steve W. Kim, Chief, Sewage Disposal Section, Water Pollution Control Division, Indiana State Board of Health, Indianapolis  
Robert W. Demaree, Chief Community Programs, Farmers Home Administration, Indianapolis.

Business Session

Election of Section Officers for 1973

## SECTION ON RADIOLOGY and INDIANA ROENTGEN SOCIETY, INC.,

Room 105

9:00 a.m. Executive Committee meeting  
to

11:00 a.m.

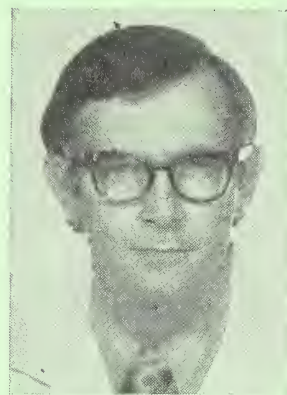
11:00 a.m. RADIATION THERAPY ROUND TABLE by Indiana University Radiation

to  
12:00 Noon Therapy Department

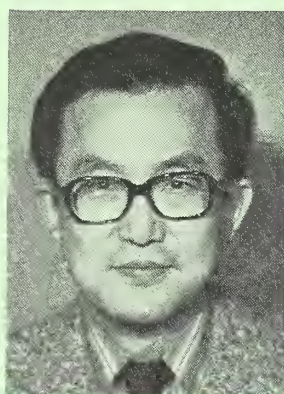
Ned B. Hornback, M.D., Indianapolis, Chairman, Department of Radiation Therapy, Indiana University School of Medicine



## SPEAKERS



**EDMUND A. FRANKEN, JR.**  
Indianapolis  
Associate Professor, Indiana University  
School of Medicine; M.D. degree from  
University of Oklahoma 1961.



**HEUN Y. YUNE, M.D.**  
Indianapolis  
Professor of Radiology, Indiana Uni-  
versity School of Medicine; consultant,  
Bill-Wilkerson Speech and Hearing  
Center, Nashville, Tenn. M.D. degree  
from Severance Medical School 1956.



**WALLACE S. TIRMAN, M.D.**  
South Bend  
Assistant Professor Radiation Therapy,  
Indiana University School of Medicine;  
attending radiologist, Memorial Hos-  
pital, South Bend, and Elkhart Hos-  
pital, Elkhart. Received M.D. degree  
from State University of New York  
in 1937.



**GLENN W. IRWIN, JR., M.D.**  
Indianapolis  
Dean, Indiana University School of  
Medicine

- 12:00 noon Luncheon, Room 123  
to Election of 1973 Section Officers  
1:30 p.m.
- 2:00 p.m. "PULMONARY ANGIOGRAPHY IN  
TENSION DISORDERS OF CHIL-  
DREN,"  
Edmund A. Franken, Jr., M.D., India-  
napolis
- 2:30 p.m. "ANGIOGRAPHY OF THE PARA-  
THYROID IN HYPERPARATHY-  
ROIDISM,"  
Heun Y. Yune, M.D., Indianapolis
- 3:00 p.m. "ARTHROGRAPHY OF THE KNEE  
to AND SHOULDER,"  
4:00 p.m. Wallace S. Tirman, M.D., South Bend

## SECTION ON SURGERY, INDIANA CHAPTER, AMERICAN COLLEGE OF SURGEONS and INDIANA CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

- 8:30 a.m. Buses leave Indiana Convention-Exposi-  
tion Center for Indiana University Medi-  
cal Center and Marion County General  
Hospital and Myers Auditorium
- 9:00 a.m. Greetings and introductory remarks:  
Glenn W. Irwin, Jr., M.D., Dean, Indiana  
University School of Medicine  
"THE MEDICAL EDUCATIONAL  
PROCESS IN INDIANA,"  
Steven C. Beering, M.D., Associate Dean,  
Indiana University School of Medicine
- 10:00 a.m. Guided Tours — IUMC/MCGH Facil-  
ities
- 11:30 a.m. Buses return to Indiana Convention-Ex-  
position Center
- 12:00 Noon Luncheon, Room 125

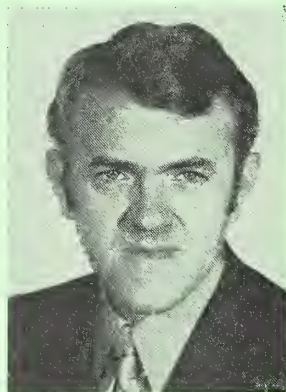
## SPEAKERS



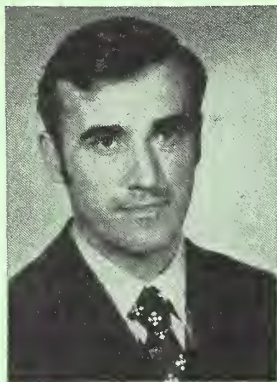
**JAMES A. MADURA, M.D.**  
Indianapolis  
Faculty, Indiana University School of Medicine; consultant, Veterans Hospital, Marion County General Hospital; former NIH academic trainee, Ohio State University Department of Surgery; received M.D. degree from Western Reserve University 1963.

**JOHN L. GLOVER, M.D.**  
Indianapolis

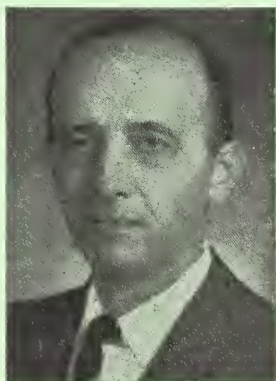
Associate professor of surgery, Indiana University School of Medicine; consultant, Veterans Hospital; chairman of Department of surgery, Marion County General Hospital, Indianapolis; member of transplant team since 1967. Received M.D. degree from Vanderbilt University 1958.



**JOHN PATRICK DONOHUE, M.D.**  
Indianapolis  
Professor and chairman, department of Urology, and chairman, Renal Transplantation Program, Indiana University Medical Center; consultant, Veterans Administration Hospital, Marion County General Hospital, Methodist Hospital, St. Vincent Hospital. Received M.D. degree from Cornell University 1958.



**ROBERT J. ROHN, M.D.**  
Indianapolis  
Faculty, Indiana University School of Medicine; consultant, West Tenth Street Veterans Administration Hospital; specialty, hematology; M.D. degree from Ohio State University 1943.



**JOHN E. JESSEPH, M.D.**  
Indianapolis  
Professor and chairman, Department of Surgery, Indiana University School of Medicine; consultant, Veterans Administration and Marion County General Hospitals. Received M.D. degree from University of Washington 1953.

2:00 p.m. General Session, Surgical Section  
**PROBLEMS IN RENAL TRANSPLANTATION**

**"MANAGEMENT OF THE ANEPHRIC PATIENT,"**

Stuart A. Kleit, M.D., Indianapolis

**"LOGISTIC AND POSTOPERATIVE PROBLEMS IN THE TRANSPLANT PATIENT,"**

James A. Madura, M.D., Indianapolis

Panel Discussion:

Participants: John L. Glover, M.D., Indianapolis

John P. Donohue, M.D., Indianapolis

James A. Madura, M.D., Indianapolis

Stuart A. Kleit, M.D., Indianapolis

**"USEFUL TECHNIQUES IN CANCER CHEMOTHERAPY,"**

Robert J. Rohn, M.D., Indianapolis

3:00 p.m. Coffee Break

3:45 p.m. **"CURRENTS IN SURGICAL EDUCATION,"**

John E. Jesseph, M.D., Indianapolis



# Auxiliary Program

(All Events will be in the Indiana Convention-Exposition Center)

President—Woman's Auxiliary to the Indiana State Medical Association—Mrs. Philip L. Smith, Fort Wayne

General Chairman of Women's Activities—Mrs. Richard B. Schnute, Indianapolis

Reservations—Mrs. Richard C. Powell, Indianapolis

Hospitality and Registration—Mrs. Malcolm O. Scamahorn, Pittsboro

Publicity—Mrs. William A. Kleifgen, Fort Wayne

Art and Hobby Show—Mrs. Harry Siderys and Mrs. Harold G. Halbrook, Indianapolis

## Monday, October 16, 1972

8:30 a.m. Art and Hobby Show—Viewing—Hall C to  
4:30 p.m.  
9:30 a.m. Registration—Concourse  
9:30 a.m. Opening of technical and scientific exhibits, Hall C  
1:00 p.m. Guided Tour of the City (Stop at Speedway to  
4:00 p.m. Buses will leave from and return to Indiana Convention-Exposition Center  
5:30 p.m. Cocktail Party, Reception Room (Courtesy of the Seventh District Medical Society)  
8:30 p.m. Program on "ACUPUNCTURE" presented by Wei Ping Loh, M.D., Gary, Room 210 (Members and guests invited to attend program which is sponsored by the Women Physicians of the Indiana State Medical Association)

## Tuesday, October 17, 1972

9:30 a.m. Art and Hobby Show—Viewing—Hall C to  
4:30 p.m.  
9:30 a.m. Registration continues, Concourse  
10:00 a.m. Open Board Meeting, Woman's Auxiliary to the Indiana State Medical Association, Room 253, Mrs. Philip L. Smith, President, presiding

11:30 a.m. Social Hour, Room 125  
12 Noon Luncheon, Room 125  
2:00 p.m. General Meeting, Room 210 to  
(Women are invited and urged to attend this meeting) Call to order by Peter R. Petrich, M.D., ISMA President  
4:00 p.m. HEALTH CARE DELIVERY IN U.S.—"WHO, WHAT, WHERE AND HOW MUCH?"  
Moderator: Peter R. Petrich, M.D.  
Panel: Congressman Jerry L. Pettis (R) California  
Congressman Peter N. Kyros (D) Maine  
Russell B. Roth, M.D., Erie, Pennsylvania, President-Elect, American Medical Association  
6:00 p.m. President's Reception and Reception for Fifty Year Club, Reception Room  
7:00 p.m. President's Dinner, Ballroom

## Wednesday, October 18, 1972

8:30 a.m. Art and Hobby Show—Viewing to  
12:30 p.m.  
10:00 a.m. Coffee—Morris Butler Home (Historical Landmark) 1204 N. Park Avenue  
Walking Tour of Broad Ripple Village Shops. (Transportation will be provided both to Broad Ripple area and Butler Home.)

HOSPITALITY ROOM—Room 121 will be open from 9:30 a.m. to 4:30 p.m., Monday, Tuesday and Wednesday. We hope all women attending the meeting will visit in the Hospitality Room.

# Reports of Officers

## Executive Secretary

The following is the report of the actions of the 1971 House of Delegates regarding resolutions and the disposition of those actions.

**RESOLUTIONS:** 71-2. *Restrictive Covenants*. Introduced at the AMA Clinical Meeting on November 1971 and was referred to the Judicial Council and reported back to the AMA House during the 1972 annual meeting. The matter was again referred back to the Judicial Council for further study.

71-3. *Declaration of Non-Participation Policy*. This was referred to the Board of Trustees and was reported to the House in Report A of the Board at this session.

71-4. *Medical Department, Board of Corrections*. This was again introduced in the 1972 Legislature and again was not passed into law.

71-5 and 71-17. *Both Dealing with a Moratorium on Amphetamine Drugs*. We have no knowledge of the number of physicians who have followed this recommendation.

71-7. *Invasion of Patient Privacy*. This was referred to the Board of Health and the Commission on Legislation. The form was changed by the Board of Health so that legislation was not necessary.

71-8. *Newborn Insurance Coverage*. A copy of this resolution was transmitted to the State Insurance Commissioner.

71-11. *Report of Annual Meeting*. Referred to the Budget Committee and the Board of Trustees. Allocation of funds was increased by these groups for the 1972 meeting.

71-12. *AMA Coding and Nomenclature System*. While adopted by the House, Blue Shield has taken no action to change to this system. We understand that it is a matter of economics as far as the Blues are concerned.

71-13. *Qualified Trainers in Sports Activities*. This resolution was forwarded to the State Superintendent of Public Instruction and to the Indiana High School Athletic Association.

71-14. *Continuing Medical Education*. Referred to the Commission on Medical Education and Licensure. Plan is being submitted to the House in the report of the Commission.

71-15. *Statewide Continuing Medical Education*. This resolution was also referred to the Commission on Medical Education and Licensure and they are reporting back to the House in their report at this session.

71-16. *Redefining Medical Districts*. Appropriate changes in the Bylaws have been made to conform to the action of House in the 1971 session.

71-18. *Federal Legislation By-Passing Local Health Departments*. This was referred to the Commission on Legislation.

71-19. *Parameters for Medicare and Medicaid Services*. Copies of this resolution were forwarded to HEW and the Indiana Congressional delegation.

71-23. *Recent Third Party Activities Concerning Graduate Medical Education*. Referred to the Commission on Medical Education and Licensure.

71-24. *Flow of Illicit Drugs From Communist China*. Referred to the Board of Trustees for further study and, on investigation, it was the recommendation of the Board that this resolution not be adopted.

71-25. *Health Manpower*. Introduced by the Indiana delegation before the AMA 1971 Clinical meeting. It was referred to the Board of Trustees and reported back to the House at the 1972 annual meeting. The recommendation of the Board that the resolution not be adopted was sustained by the House of Delegates.

## MEMBERSHIP:

Membership continues to show a slow but steady growth and I present herewith a comparison of membership of the last 10 years of the association, showing the gain and loss by years. Also in the figures below is the number of members that Indiana has in the American Medical Association. The final column in the report shows the number of Indiana

State Medical Association members who have not seen fit to belong to the American Medical Association. While the membership in the association has shown a steady but slow growth, our membership has not grown as rapidly as some of the other states. Indiana seems to remain a state for producing physicians for other states and, according to the Dean of the Medical School, we do have more interns and residents in Indiana this year than we have had for a number of years. Hopefully this will reflect itself in additional manpower practicing medicine in Indiana and eventually becoming members of the Indiana State Medical Association.

The increasing number of physicians who are not members of the American Medical Association should be of some concern to this House. You will notice that the drop off in the last three years has been rather rapid. Indiana is getting close to the mark of losing one of its delegates to the American Medical Association as the delegate apportionment is on the basis of one delegate for each 1,000 members or fraction thereof. While most of these non-members may have an honest difference of opinion with the AMA policy, nevertheless if there was ever a time when organized medicine should be bound together with a unified voice to combat some of the things which are facing the organization today, this is the time. It is hoped that, upon investigation by these members, they might reconsider their action and rejoin the American Medical Association and add strength to our forces at all levels of government.

We have, for years, had the State Board of Medical Registration and Examination commenting upon the number of physicians in Indiana. We have seen the American Medical Association reports indicate a different number of

## ANALYSIS OF MEMBERSHIP TREND OVER PAST 10 YEARS

Year	ISMA 7/31	Gain Loss	AMA 7/31	Gain Loss	ISMA Members Non-AMA Members
1961	4298		4178		120
1962	4307	+ 9	4184	+ 6	123
1963	4330	+23	4222	+38	108
1964	4331	+ 1	4225	+ 3	106
1965	4356	+25	4255	+30	101
1966	4367	-11	4254	- 1	113
1967	4356	-11	4180	-26	176
1968	4400	+44	4246	+66	154
1969	4450	+50	4301	+55	149
1970	4457	+ 7	4291	-10	166
1971	4489	+32	4236	-55	253
1972	4526	+37	4179	-57	347



physicians in Indiana, as compared to our records.

In view of this, we obtained a listing from the State Medical Board, a listing from the American Medical Association, and we are checking these county by county. We find that many of these physicians who are listed in cities in the state of Indiana are not known or have not been heard of by the county medical societies. This study is also pointing out that apparently there has not been much effort made in those counties having interns and residents to bring them into membership in their county society. It would be fine if these counties would encourage interns and residents to join their societies and the Indiana State Medical Association and the American Medical Association to encourage these new doctors to work with organized medicine in resolving the problems of the profession. There also seems not to be much activity in bringing osteopaths into membership in county medical societies since the House of Delegates changed the rules to permit osteopaths to become members of the State Medical Association and the American Medical Association. This would also be a source of membership if osteopaths throughout the state are deemed to be eligible for membership by the respective county medical societies.

The field staff of the association stands ready at any time to be of assistance to county societies in calling upon or encouraging eligible individuals to place their application for membership in their respective societies.

#### CHAMPUS:

The administration of the CHAMPUS program by your Association continues to draw plaudits from the Army for the method by which we have been handling it. The national goal for claims backlog is 10 working days. Indiana has been running between 3 and 5.4 days, which is well below the national average. During the year beginning August 1, 1971, and ending July 31, 1972, the Association processed 17,510 claims amounting to \$1,453,131.16. While the activity in this department has increased year by year, as a result of visitation by one of the officers from Denver in July, indications were that the department will be further expanded before the coming year ends.

#### FIELD SERVICE:

The field service has been actively engaged this past year in checking out the

number of doctors in each county in the state of Indiana, as well as again visiting the members of the state legislature and serving as lobbyists during the legislature. Legislation activities are taking more and more of the fieldmen's time and keeping them, therefore, out of their districts which, we hope, will soon be put to an end by the employment of a person to handle most of this work.

#### LEGISLATION:

Your secretary believes that it might be worthwhile to repeat portions of the report he made to the Board of Trustees at their meeting on January 9, 1972. This is not necessarily to be repetitious but I feel that the members of the House of Delegates should be aware of some of these matters.

Up until the year 1972 we had a session of the legislature lasting 60 working days in odd-numbered years. The voters approved a constitutional amendment so as to hold an annual session of 30 working days in the even-numbered years in addition to the sixty working days in odd-numbered years.

1972 marked the beginning of the 30 day sessions. Some of you may not know how the state legislature operates. In the past it was customary for organizations or individuals to write a bill and then solicit some member of the legislature to introduce the bill. You would then hand this bill to the member who would take it to the Legislative Bureau and have it checked for constitutionality and jacketed and numbered. When the legislature convened, each legislator was permitted to introduce "x" number of bills per day and these were referred to committees of the House or Senate who held public hearings on them and then reported them to the floor of the Senate or the House with recommendations that the bill do pass, do pass as amended, or they would kill the bill in committee by not reporting it out on the floor. There were many times when the bill as originally introduced was stripped entirely of its contents in committee and another bill inserted, which means that you had to be on constant alert to review all bills and constantly watch the action of the committees as well as the floor of the House and Senate to be sure that something was not slipped in that would be harmful to the medical profession.

Beginning with the '72 session, we are now in an entirely different ball game. The legislature of 1971 created a legislative council which is a rather all-powerful agency that rewrites all bills, numbers them, and sometimes even selects

the member of the legislature who will introduce them, which means that we have a 12 month per year working force working on bills for the legislative session. In 1972 bills were numbered and referred to committees early in November of 1971, although the legislative session of the House did not begin until January 11, 1972. Bills introduced in November and December were already referred to various committees of the House and Senate and most of these committees held public hearings on these bills and took action as to their disposition even prior to the date of the beginning of the session on January 11th.

As of January 9, 1972, your secretary reviewed some 54 bills in the '72 session that had something to do with health or the practice of medicine. I will predict at this time that the time is very short before we will have a full time professional, year around legislature in the state of Indiana. This activity then raises a question as to what your association is going to do regarding coverage of the state legislature.

Today legislative council committees are meeting weekly and we have been attempting to cover them by using the field staff. The Board of Trustees has finally given permission to the secretary to employ a person to operate in this particular field and handle these legislative matters. Hopefully, this can be accomplished before the first of the year.

With the trend toward a full time legislature, it means that physicians in respective county societies from where the men are elected should make a sincere effort to be in constant contact with these men and offer their advice and counsel on measures which appear before the legislature affecting the public health and the practice of medicine.

#### PUBLIC RELATIONS:

At the January meeting of the Board of Trustees I reported among a number of other items of vital concern to the Association the need for a public relations program.

I told the Board, and I quote from my own report, "This is an important and integral part of any association and while we have limped along with a meager P.R. Program, we have never really sat down and determined what we should do in the way of a full blown public relations program. As I point out in my report, some of the suggestions in this particular area, and I might add that plans for some of these are already on the drawing board, or I should say in the blue print stage, it is



going to cost us approximately \$25,000 to launch such a program. I believe it is time that we decide to institute an organized P.R. campaign and discontinue our hit-and-miss attitude that we have had on this subject. Of course, this costs money too."

In developing the "blue print" for a public relations program the Association should consider that the continuing criticism of organized medicine by its members is that it is not "telling its story to the people." Consequently, such a program should be geared to accomplishing this. This program should include material which would emphasize throughout how ISMA activities benefit Hoosiers.

The various means of communication would be provided by the following:

1. Television Spots
  2. Radio Spots
  3. Newspaper Ads
  4. Indiana Magazine Ads
  5. Billboard Posters
  6. Exhibits
- Subjects which would be communicated through the above six areas and which would have appeal to the public would be:
1. Legislation
    - Development of Physicians' Assistants' Programs
    - Statements on National Health Insurance
    - ISMA support of public health measures
  2. Rural Health
    - Measures being taken by ISMA to help find solutions to the doctor shortage
  3. ISMA concern with the high cost health care and steps being taken to help solve the problem; i.e., utilization review, etc.
  4. Activities in the drug education field and treatment of the addict.
    - Use of Hoosier Teen Health Happening tapes and films and distribution of drug literature.
  5. ISMA concern with continuing medical education and programs now being developed for Indiana doctors.
  6. Emergency medical services — ISMA activity in this area; i.e., upgrading ambulance services, improving emergency rooms in hospitals, proper use of the emergency room by patients, etc.
  7. Preceptor program — emphasize the efforts of the ISMA to encourage young doctors to stay in Indiana to practice.
  8. ISMA Convention activities with

emphasis on resolutions, reports and actions of the House, which affect the Indiana public.

9. Cooperative projects with I. U., voluntary health agencies, Blue Shield, hospital association, etc.
  10. ISMA policy and attitudes of physicians in the socio-economic area.
    - Doctor-Patient relationship
    - Relationships with health insurance carriers, governmental medical programs, etc.
    - Statistics on doctor-to-population ratios, comparisons of medical costs with health care costs and other costs, etc.
  11. Communication of health tips on current problems such as drug usage, alcoholism, heart disease, etc.
  12. Explanations of the ethics of medicine.
  13. Grievance Committee activities and reasons for existence.
  14. Structure of ISMA, with emphasis on local physician involvement.
  15. Promotion of certain literature items available through ISMA and AMA. Keep supply on hand to meet requests.
  16. Medicine as a career as well as other medically related career opportunities.
  17. Quackery in medicine with emphasis on chiropractic.
  18. Standards for athlete physical exams being developed by Commission on Sports and Medicine.
  19. Increasing activity of physicians and clergy working together with patients.
  20. Student loan program of the ISMA.
  21. Future plans of organized medicine which relate to the public.
- Booklets which might be developed are:
1. Booklet on how to avoid malpractice suits already in final planning stages).
  2. Drug treatment booklet (now being planned by the Subcommittee on Drug Addiction and Alcoholism).
  3. Booklet on current problems in nursing homes (now being formulated by Commission on Aging).
  4. A code of cooperation for physicians, hospitals, TV, radio and press.
  5. A booklet on poisons and actions to be taken by individuals before seeing the doctor.
- These are only a few suggestions which could be utilized in setting up a

continuing program of public relations. The list can be added to endlessly as new ideas develop each year through the Board of Trustees and its committees and commissions.

In the past it has always been the Association's action to take steps in a public relations sense when a specific problem would arise. This is a "too late" procedure and meeting problem issues is only a minute part of public relations.

A continuing public relations effort would be similar to a continuing advertising program by a large corporation to sell the name of the company and specific products produced by the company.

In a similar sense, the Public Relations of the ISMA would function. It would be based on the good works of the Association and its members on a year round basis through the media mentioned earlier in this report. It could also meet the demands of current problems as they arise for the profession, and rather than be stamped as a negative and do-nothing group, the ISMA could develop for itself a new personality based on its continuing interest in and accomplishments for patients and public.

At the time of the writing of this report I am aware that the Commission on Public Information may be submitting a request for budget support for the proposal which I have outlined. I would urge the House of Delegates to give serious consideration to such a program.

USE OF BUILDING:

From January through the end of August, we have a record of the following meeting schedule, and this includes a seven-day week schedule since most committees meet on Saturday and/or Sunday.

—Meetings held in Headquarters Office .....	71
—Included in the above figure are: ISMA Commissions and Committees .....	56
—Included are other related medical groups and specialty societies and such groups as Directors of Medical Education and Indiana Regional Medical Program Board .....	15

This includes 71 actual days of the 244 days during this series of months, over two months of time spent in Headquarters operation in an eight-month period, and out of 37 Sundays, the building was open 17 for meetings.



It can readily be seen that the meeting schedule is on the increase, with more and more medical and related groups taking advantage of the excellent meeting facility.

#### *ISMA SERVICES TO OTHERS:*

Your association headquarters remains a constant source of inquiry; requests for assistance and advice in the field of medical care and other health related areas. Each day brings requests from the public or government offices or others things daily carried on in your headquarters office which are separate from the projects and considerations of the commissions, committees, Board of Trustees, and special committees which during the year work in different project areas, all of which are staffed and coordinated by the headquarters office.

1. Almost daily we have requests for information on the Indiana law pertaining to foreign physician licensure in Indiana to individuals, Universities in other states.

2. We have prospective medical students asking us for information concerning entering the medical school.

3. Provide the American Medical Association with information concerning the activities of our committees and commissions.

4. Provide the AMA News with material pertaining to the Indiana State Medical Association and newspaper clips on periodic basis.

5. Prepared orientation kits for use by the field staff in contacting new physicians locating in Indiana.

6. We continue to provide tapes and video tapes of the Hoosier Teen Health Happening to television stations and to the schools in the state of Indiana.

7. Assisted out-of-state physicians in acquiring information on Indiana licensure laws.

8. Provide kits and materials on drugs and drug abuse to students, teachers and physicians.

9. Provide materials to health teachers for development of health and safety files for teaching purposes.

10. Provide many materials on a variety of health subjects for research papers.

11. Assist county societies in procuring films and speakers for their meetings.

12. Assisted in promotion of district society meetings.

13. Provide news stories and background information to the news media on association activities and policies.

14. Provide information to members

of the Indiana General Assembly on ISMA policies regarding bills which will have an effect upon the public health and the practice of medicine.

#### *SERVICES TO MEMBERS:*

While the association has instituted many new services to members, there are other areas which might be well worth exploring. With the computer age being here, it might be well for the association to give some thought to developing a computer system for handling the billing, accounting and tax services for members of this association. The rapid development in the capability of a computer system would make it easy for a doctor to install a console in his office from which he could daily have his office girl transcribe to the computer his office calls for that day and the charges to be made. Such a system would be a very economical one if it was proved to be successful and feasible and a large portion of our members joined in the function of such a program. In any event, I would urge that the Association study this particular area of additional service to the membership of this association.

#### *WELFARE PROGRAMS:*

As though we don't have enough problems already existing in the various welfare programs and Federal programs for welfare recipients, we now have another one which is going to be forced upon us in June of 1973. New regulations have been issued to take effect at that time which provide that states must make possible for all youth under 21 years of age to receive health screening, diagnosis and therapeutic care under a new program at the expense of the government. It is estimated this will encompass approximately 200,000 more individuals in the state of Indiana and that a minimum conservative cost has been estimated by the budget department of costing the taxpayers of Indiana a minimum of \$50,000,000 per year.

Those of you who have been following the newspaper reports are well aware of the difficulties existing now between the welfare department and the state legislature. It is rather evident from reading the papers and sitting in the council meetings of the state legislature advisory committee that things are not well as far as controls of these programs are concerned.

Your Association has been approached about developing a plan either at state or regional level for the purpose of handling both utilization and peer

review under the welfare program.

In discussing this with some of the welfare officials it appears that we may be reverting back to the old county review committee system which we had years ago and which apparently worked very well.

Several states have undertaken this responsibility, the latest being the state of Illinois, in which the state medical society is handling these programs and problems for their state government. Georgia, for example, the state medical association there handles all the programs of welfare, Medicare for not only physicians but hospitals as well. The dilemma, no doubt, is brought about by many involved who do not have medical background or knowledge and do not know how to put the program together to make it work. Therefore, it appears that the government is beginning to look to medical organizations to try and pull them out of this dilemma. This, perhaps, is another area which we should probably dig into with a serious study as to what, if anything, medicine can do or is willing to do with respect to assisting and controlling this growing cancer.

#### *ANNUAL MEETING:*

I would like again to reiterate what I reported to the House in 1971 and to the Board of Trustees at their meeting in January of '72, that the time has come for us to give serious consideration to methods of financing our annual meetings. The activities of your association and of your annual meeting have been caught in the inflation spiral the same as everything else. At the same time, the demand for exhibit space is consistently falling.

Guest speakers are more expensive, transportation and housing for these people are more expensive and in order to give a well rounded program it necessitates bringing in more and more speakers for each annual meeting. The cost of your annual meeting is nearing the figure of \$30,000 per year and exhibit income is dropping a few thousand each year; so it means that either we discontinue the annual meeting, or we increase the dues to pick up the difference, or we charge registration fees, or we charge a fee for participating in the scientific programs. The Finance Committee of the Board of Trustees currently has had the matter under study and, I believe, will make a recommendation to the House concerning this problem. I would hope that you would support the Finance Committee in whatever decision they reach regard-



ing your annual meeting. I think your meetings are going to continue to grow in importance and in character, as more and more of the specialty groups and the sections take on the responsibility for the scientific presentations made at our annual meeting.

It is hoped, too, that the Delegates from the various counties will go back home and encourage the members in their respective societies to actively participate in our annual meeting, because a large attendance also helps sell exhibit space and thereby cuts down the necessity of the Association picking up the deficit.

THE YEAR AHEAD:

As one looks ahead I am sure that there will be no decrease in the necessity of your Association being active in more and more fields than they have ever been in their history. We are seeing the development of more and more health programs. The push for the establishment of HMOs, the push for the establishment of group practice clinics in order to handle some of the welfare programs, and no doubt some attempt is to be made to delimit the number of visits a person may see their doctor and perhaps even the establishment of a Federal fee schedule and treatment method.

Continuing education is going to be an important adjunct to this Association during the coming year and I am sure that with some of the ideas expressed by the incoming officers and some of the commission people, we can anticipate a busier year than we have had in a decade

as far as the activities of your Association is concerned.

Communications continues to be a problem in getting the message down to the individual doctor as to what his organization is doing in his behalf. We are hopeful that more societies will invite ISMA officers to visit with them at least once a year to discuss some of the activities of the Association and some of the things that organized medicine is attempting to do in the interest of the individual member.

As I mentioned before, computer technology—not only in the practice of medicine but in the business aspect of the physician—will show great advancement during the coming year. Supplying health manpower to satisfy the needs of this state is a problem we will face in the coming year. The role of third parties must be closely watched during the coming year. As previously pointed out, legislative activities are going to be speeded up tremendously during the coming year.

The Indiana State Medical Association cannot afford at this time in history to turn over to other organizations its own responsibilities in any one of the suggested problem areas I have outlined. Neither can we remain static. We will regress or we will progress.

In the 123 years of the organization of the Indiana State Medical Association, we have an enviable history of progress in resolving any problem that threatened the health of the public of our state. The activities of your organization at the present time, the leadership which

you are providing, the interest that more members are showing in the commissions and committees and their activities, should be assuring to all that, regardless of what the situation is, Indiana physicians will lead in resolving and bringing solutions to any area in which we might be confronted.

Your staff is ready and willing at all times to carry out to the best of our ability any program devised for the furtherance of this association, the welfare of the physician and the protection of the public health.

JAMES A. WAGGENER,  
Executive Secretary

The Treasurer

Listed below are the fund balances as of July 31, 1972, in lieu of the audit which will not be available until after the close of our fiscal year September 30, 1972.

During the past year we have combined *The Journal* funds and the petty cash funds into the general fund for better accounting and control.

We have endeavored to utilize short term treasury bills for investing every possible cent of funds not immediately needed in order to earn as much interest as possible. We have exchanged our old 2.5% bonds maturing December 31, 1972, for 1976 bonds earning 5 7/8%.

Our bookkeeper, Mrs. Reilly, has provided the Budget Committee, Executive Committee and the Board with the most

INDIANA STATE MEDICAL ASSOCIATION  
Statement of Financial Condition at July 31, 1972

ASSETS	General & Journal	Building Fund	Medical Fund	Student Loan	TOTAL ALL FUNDS
Cash in banks—operating .....	56,864.38	3,821.40	1,287.85	—	61,973.63
Cash in banks—interest bearing .....	20,000.00	6,519.97	15,675.26	19,775.37	61,970.60
Short term treasury bills .....	205,019.47	93,259.97	—	—	298,279.44
Accounts receivable .....	9,565.21	384.35	127.71	65.92	10,143.19
Prepaid expenses .....	12,846.10	727.24	—	—	13,573.34
Long term investments .....	84,404.84	—	25,095.13	20,810.00	130,309.97
Property—less reserve for depreciation .....	12,430.47	414,130.89	—	—	426,561.36
Total Assets .....	401,130.47	518,843.82	42,185.95	40,651.29	1,002,811.53
LIABILITIES AND FUND BALANCES					
Accounts payable .....	8,815.29	1,205.00	—	651.29	10,671.58
Property taxes accrued .....	—	2,167.93	—	—	2,167.93
Deferred annual meeting .....	9,425.00	—	—	—	9,425.00
Dues payable to AMERF .....	19,915.00	—	—	—	19,915.00
Non-interest bearing notes .....	—	21,325.00	—	—	21,325.00
Advances from AMA .....	10,033.71	—	—	—	10,033.71
Deferred dues income .....	156,520.00	—	—	—	156,520.00
Total Liabilities .....	204,709.00	24,697.93	—	651.29	230,058.22
Fund Balances October 1, 1971 .....	190,909.78	470,496.93	36,747.98	40,000.00	738,154.69
Profit 10 months .....	5,511.69	23,648.96	5,437.97	—	34,598.62
Fund balances at 7/31/72 .....	196,421.47	494,145.89	42,185.95	40,000.00	772,753.31
Total Liabilities and Fund Balances .....	401,130.47	518,843.82	42,185.95	40,651.29	1,002,811.53



complete review of our business affairs in our entire history. These reports are carefully reviewed by the respective committees and Boards and their advice is followed by your Treasurer.

Lester H. Hoyt, M.D.  
Treasurer

## Chairman of the Board

### HIGHLIGHTS OF BOARD OF TRUSTEE ACTIVITIES 1971-1972

1. Approved the American Cancer Society's program of installing a system of telephone dialing for educational information on cancer. The system is established for utilization by Indiana physicians.
2. The Board approved the Association's endorsement and advertisement of group travel plans for the members and inaugurated the program with a trip appropriately named a "Scandinavian Adventure."
3. Approved informing the membership of a legal ruling that physicians' medical records are no longer confidential in suits by patients, and must be made available to the plaintiff and the plaintiff's attorney. The action of the Board was the result of a suit by a welfare patient against the State Department of Public Welfare for denying disability payments.
4. Recommended and approved that questionnaires circulated to physicians wishing to participate in the preceptor program be approved by the president of the county medical society and remain in the confidential files of the ISMA, with only a yes-or-no comment relayed to Indiana University for their files.
5. Approved of the president's naming a committee to work in conjunction with a Museum for Indiana Medical History, with the objective of collecting historical and significant items of Indiana's medical history and maintaining them for exposure to physicians and students. Site of the museum is the old Pathological Building on the grounds of Central State Hospital, Indianapolis. The Board later approved to recommend to Directors of the Medical Education Foundation that \$10,000 be granted.
6. Installation of kitchen in the basement of the Headquarters Building was accomplished with the approval and direction of the Board.
7. Now in progress is the publication by the ISMA of a booklet entitled,

"Physician's Liability in Patient Care" as the result of Board action upon the suggestion of the Commission on Public Information.

8. Referred to the Future Planning Committee of the Association the possibility of expansion of the Headquarters offices and the need for increasing staff. Also referred matters on building expansion to the Building and to the Finance Committees.
9. The Board increased the budget for the Convention Arrangements Commission to cover expenses of speakers.
10. Proposed merger of Blue Shield and Blue Cross staffs was discussed at length by the Board. Board directed that the trustee in each district communicate with his Blue Shield Board member personally, urging him to not promote any form of merger or combination until more information was available.
11. Approved transferring the printing of the *ISMA Journal* to another company in the interest of more satisfactory service.
12. Supported a motion that the Medical Review Committee of the ISMA, in keeping with the policy established by the House of Delegates in 1969, function only at the request of and assistance to County Medical Review Committees.
13. Approved increases in the Blue Shield-Blue Cross professional health security plan for members of ISMA.
14. Board took action to ascertain from the legal counsel of ISMA how physicians could be protected from law suits arising from the usual and customary fee concept. Board also planned an investigation of the Motors contract and Resolution 26 and how it applies to individuals rather than to the society.
15. Funding for continuing medical education programs for physicians, externs, interns and medical residents, under the Indiana Plan for Medical Education to receive support by ISMA through appropriate legislation. Board approved joining with Indiana Hospital Association, the Indiana University School of Medicine and Directors of Medical Education in promoting legislation for funding.
16. At the time of this report the Board had been approached with a proposal to jointly field staff the Regional Medical Program with the ISMA Field Service. The Board tabled the proposal until more details on such a combined effort would be forthcoming.

17. Board approved the purchase of 20,000 copies of a booklet on "Medicare Misconceptions" for distribution to ISMA members. The booklet explains in simple, direct language to patients what Medicare does not cover.

18. Concerning the National Health Service Corps and the assignment of Public Health Service physicians to physician shortage areas in Indiana, the Board moved that those areas requesting certification of the need in an area from the Indiana State Medical Association be investigated by the ISMA District Trustee, through the County Medical Society, and a report made to the Board at the next meeting following the request for approval.

19. In line with this action, the Board also advised the Headquarters Office of the Association to send a digest of the law in the Newsflash to all county societies so they will be informed in advance of any such plan for their communities.

20. A letter to the Headquarters Office of the ISMA from the Joint Commission on Accreditation asking for information on medical staff problems in six Indiana hospitals was reviewed by the Board. After much discussion the Board delayed action, contingent upon reports from trustees as to the specific situations, hospital by hospital, referred to in the letter.

21. Board approved the development by the Headquarters staff of a brochure or fact sheet detailing information regarding Medicaid and Medicare, for distribution to the membership.

22. A plan for reorganization of local health departments in Indiana was submitted to the Board by the Commission on Public Health. The Board accepted the report and appointed a committee of the Board to develop a plan for action.

23. Board discussed the National Communicable Disease Center's statement presented by the State Health Commissioner concerning "health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination." Dr. Andrew C. Offutt, State Health Commissioner, presented his statement to the Board which said, in essence, that "immunization remains a medical decision." The statement further said, "It is submitted that to change the policy in Indiana, where we have never felt the need for a compulsory immunization statute, is unnecessary and should re-



main a medical judgmental activity, and that smallpox vaccination be continued as in the past." The Board adopted the statement.

24. Board approved Public Information Commission's proposed placard on questions and answers in the medical, socio-economic fields. The placards would be utilized in physicians' offices for patient education.

25. Board approved the distribution of a booklet to all members through the ISMA *Journal* on "Treatment of Acute Drug Intoxication."

26. Resolution 71-3, Declaration of Non-Participation Policy, was reviewed by the Board and referred back to the House of Delegates with amendments.

In addition to these specific actions, the Board of Trustees at each meeting received in-depth reports from the Indiana University School of Medicine, the Indiana State Board of Health, Blue Shield, Department of Welfare and other groups.

The Board also plans and participates annually in such programs as the Washington legislation's visitation program, student-faculty-ISMA member meetings and a number of other activities which are not listed in this report.

JOE DUKES, M.D.,  
Chairman

## First Trustee District



GILBERT M. WILHELMUS,  
M.D.,

Trustee

The annual meeting of the First District Medical Society was held on April 13, 1972, at the Petroleum Club in Evansville. The meeting was well attended with over 160 members and their wives (in fact, reservations had to be curtailed because the Club could not serve a larger group). Mead Johnson Company was host for our social hour preceding the dinner.

Dr. Joseph C. Robert of Richmond, Va., who holds many honorary degrees from Furman University, Washington Lee University, Medical College of Virginia, etc., was our speaker. This noted lecturer, author, and educator spoke on the subject of "The Healing Arts In The American Way." Dr. Peter Petrich,

ISMA president, and Dr. James Gosman, ISMA president-elect, were present and gave an excellent and comprehensive report on our business at the state and national level. Dr. Gilbert Wilhelmus, trustee, gave a report in regard to the AMA's Socio-Economic meeting held in Ft. Lauderdale, Fla., and a more detailed report in regard to state medical business related to the First District. Dr. Willard Barnhart, First District representative on the Blue Shield Board of Directors, and Mr. Herbert Dixon, vice president of professional relations, gave a report on the activities of Blue Shield.

After the meeting the following officers were elected:

Bernard Rosenblatt, M.D., president

William Dye, M.D., vice president

John Winebrenner, M.D., secretary-treasurer

As in the past, postgraduate medical education is one of our primary interests in the First District. The number of interns and residents is increasing yearly. Frequent symposiums and lectures given by the Indiana University Medical School faculty are well attended. Many of our physicians are extending their postgraduate education to such far away places as the Scandinavian countries, Africa, and the Far East.

As in the past, now, and probably will be in the future, government involvement in medicine was discussed at our medical society meetings. With Phase II starting the past year, this has been thoroughly researched and the members have been informed of the "do's and don't's" of this program.

One of the values of the experience of being a member of the Board of Trustees of the Indiana State Medical Association is the opportunity of seeing how organized medicine is attempting to help each and every one of the physicians in the organization. It is obvious that whether a person is a specialist or a general practitioner, practicing in a large or a small community, the problems are very similar.

The Trustee wants to thank the many members of the District for their cooperation and activity in their local medical society and participating on the Commissions and Committees of the ISMA. The District appreciates the efforts of Mr. Robert Amick for his attendance and suggestions throughout the entire district.

The Trustee is grateful for the cooperation and the opportunity to serve his fellow physicians in the First District.

GILBERT M. WILHELMUS, M.D.

Trustee

## Second Trustee District



JOSEPH E. DUKES,  
M.D.,

Trustee

The Second District annual meeting was held Thursday afternoon May 18, 1972, at the Officers Club of Crane Naval Depot. Greene County Medical Society was the host with Robert E. Moses, M.D., presiding, and J. S. Brown, M.D., as secretary. There was a good representation from each county.

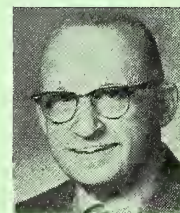
The meeting featured Ray W. Gifford Jr. M.D., head of the Department of Hypertension and Renal Diseases, Cleveland (Clinic Foundation) Cleveland, Ohio. His subject was "Management of Hypertension—Is It Really Worth While Treating?" A question-and-answer period followed his talk.

The Crane Medical Department then presented a film about the Crane Naval Depot. This was a very informative film concerning the activities and works of the depot.

A business meeting was then held prior to the dinner hour, at this time a new trustee for the Second district was elected, Dr. Paul W. Holtzman of Bloomington. Owen-Monroe County extended an invitation to be hosts for the Second district meeting next year.

JOSEPH E. DUKES, M.D.,  
Trustee

## Third Trustee District



ELI GOODMAN, M.D.

Trustee

The 1972 meeting of the Third District was held at New Albany in the Robert E. Lee Inn. Presiding was Dr. Daniel Cannon.

This meeting was held simultaneously with the annual meeting of the Third District Academy of Family Physicians.

The trustee gave a report of activities of the Board of Trustees of the Indiana State Medical Association and made a special plea for solidarity and support of both the Indiana State Medical As-



sociation and American Medical Association.

An excellent afternoon and after-dinner program about problem oriented history taking was presented.

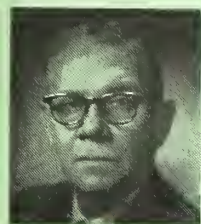
After some discussion about the continuity of District and State meetings, it was voted to change the annual District Meeting date from May to September.

Dr. Claude E. Meyer was elected president and Dr. Robert McKechnie was elected secretary-treasurer of the District.

The 1973 annual meeting of the District will be held in September at the Marriott Inn in Clarksville.

ELI GOODMAN, M.D., *Trustee*

#### Fourth Trustee District



JACK E. SHIELDS,  
M.D.,  
Trustee

The District meeting of the Fourth District was held in Madison at the country club on May 17th. The evening dinner was well attended. Our main speaker was a celebrity of the news media from Channel 3 in Louisville and gave a rather humorous presentation.

Members of the District were particularly pleased that the ISMA president and president-elect attended the meeting. Jim Waggener, executive secretary, was also present. This, also, the District appreciated.

A golf game was held in the morning with co-winners: Dr. Leslie Baker of Aurora, Dr. Bob Zink of Madison.

Elections were held by the delegates from the different counties. Dr. Shields, who accepted the office of trustee from the Fourth District a year ago and at that time stated he would hold the office for a year and would in the meantime hunt for a qualified young physician to take his place. Dr. Howard Jackson of Madison was nominated and then elected trustee without opposition, and he was elevated from his position of alternate trustee. A young physician from Seymour, Dr. William Blaisdell, highly qualified for this position, was nominated and elected without opposition to the position of alternate trustee. This, in fact, makes District Four with the youngest trustee and alternate trustee of any of the districts in Indiana. Of course Dr. Shields resigned as he stated he would.

Dr. Black, who is at present on the

Blue Shield Board and has been for many years, was nominated to succeed himself in this position. In opposition, Dr. Alvin Henry, ophthalmologist from Columbus, was nominated. With a very close vote, Dr. Henry was elected and he will represent the Fourth District in the future on the Blue Shield Board.

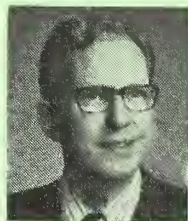
The other so-called routine elections were for president and president-elect, secretary and treasurer of this District Society for the ensuing year. Dr. Kenneth Schneider from Columbus was elected president and the next year's meeting will be held at Columbus. Dr. C. David Ryan, Columbus, was elected secretary and treasurer. Dr. Shields was elected president-elect.

There are approximately 35 doctors in Bartholomew County, the county in which next year's meeting will be held, and we are looking forward to a big meeting, well-attended, next May. That date has not been chosen.

JACK E. SHIELDS, M.D.,  
*Trustee*

(See page 982 for Fifth Trustee District report.)

#### Sixth Trustee District



PAUL M. INLOW,  
M.D.,  
Trustee

It is my pleasure to announce that Dr. Glen Ward Lee of Richmond is the new alternate trustee from this district.

This district congratulates a member, Fayette County, the home of the 1972 State Basketball Champions.

Mr. Phillip Willkie of Rushville has continued to speak for legislative change to lift restrictions for licensure of foreign physicians who wish to practice in Indiana. He sees this as a solution to easing the physician shortage in small communities.

The Sixth District Meeting was held in Shelbyville on May 3, 1972, at the Holiday Inn. There were 45 members present, with President Mark Smith presiding. Dr. Guy Owsley, Dr. D. Edmund Storey and Dr. Raymond H. Murray explained Peer Review, Medical Foundations and HMO's. Pertinent and lively discussion followed. Dr. and Mrs. Peter Petrich and Dr. and Mrs. James Gosman, president and president-elect of the Indiana State Medical Association, were welcome guests.

New officers are: President, John Moening, M.D., Greenfield; Vice-Presi-

dent, James H. Tower, M.D., Shelbyville; and Secretary-Treasurer, Davis W. Ellis, M.D., Rushville. District dues were increased from \$1.00 to \$2.00. Rush County will be host to the 1973 meeting.

Dr. Walter Judd, long-time Minnesota Congressman, was the dinner speaker. He spoke on China, world communism and the world political situation. He challenged his fellow physicians to become involved in politics so that they might have more control over the drafting of legislation affecting the practice of medicine. I believe more physician involvement in the Indiana State Medical Association would be a good place to start.

P. M. INLOW, M.D., *Trustee*

#### Seventh Trustee District



DWIGHT W. SCHUSTER,  
M.D.,  
Trustee

The Seventh District held its annual meeting on June 14, 1972, at the El Dorado Country Club, Greenwood. Dr. John Records of Franklin, as President, presided at the business meeting. In spite of heavy rain and a thunderstorm, a good number of golfers braved the El Dorado course. At the business meeting it was moved and accepted that the *District dues be increased from twenty-five cents to \$1.25 a year, in order to expand the Seventh District's activity and to make it more meaningful for its members. A \$2.00 per member assessment for 1973 only was also agreed upon.* The use of the \$2.00 assessment is to provide funds for the Seventh District to hold a reception in honor of Dr. James Gosman at the October 1972 Annual ISMA meeting. Dr. Gosman will be elevated to president of ISMA at that meeting.

The following were elected to office: Dr. Joseph Ferrara of Franklin was elected to succeed Dr. Dwight Schuster as trustee. Dr. John Pantzer of Indianapolis was elected alternate trustee to succeed Dr. Ferrara, and Dr. Don McCallum of Indianapolis was elected alternate trustee to succeed Dr. Joseph Kerlin of Danville. Dr. Stafford Pile of Indianapolis was elected to represent the Seventh District on the Blue Shield Board of Directors to succeed Dr. Glen Ryan. Dr. Eric Clark of Plainfield was selected as president elect of the 7th Trustee District. Dr. Malcolm O. Scamahorn of Pittsboro was elected Secretary-treasurer.



After dinner, Dr. Records introduced the speaker of the evening, Dr. Otis Bowen. Dr. Bowen gave an excellent address and fielded questions afterwards in a very effective fashion. At the conclusion of the meeting, Dr. Records turned the gavel over to the incoming president, Dr. Donald Stephens of Indianapolis. Dr. Stephens congratulated Johnson County for a good meeting and prophesied that the Seventh District was going to continue to grow in activity and stature. He announced the next meeting would most likely be held at the Speedway Motel in mid-June 1973.

As the retiring trustee of the Seventh District, I wish to thank all who have helped me during my tenure on the ISMA Board and to ask your continued support in my efforts as chairman of the Physicians Committee to Re-elect the President in November 1972.

DWIGHT W. SCHUSTER, M.D.,  
*Trustee*

### Seventh Trustee District



JOHN O. BUTLER, M.D.,  
*Trustee*

Dr. Dwight W. Schuster, the other ISMA Trustee representing the Seventh District, already has recounted the highlights of the district meeting held June 14 and there is no need for me to be repetitive. I shall confine myself, therefore, to a few brief observations.

Approval given to a small increase in district society dues should, in my opinion, allow the district better to promote its meetings and to encourage attendance. In the meetings, election of district representatives on the ISMA Board of Trustees and on the Board of Directors of Blue Shield, in themselves are of sufficient importance to warrant consideration by a large group of physicians.

In addition, improved financial resources should enable the district to pay adequate honoraria to speakers invited to discuss medical and socio-economic matters. The district meetings are another of the avenues of communication we need so sorely and which must be kept open.

I think it is incumbent upon district officers, as it is upon county society leaders, to keep the trustees advised of

the thinking in their medical communities for, without direct contact, trustees can only guess as to the opinions of those they represent.

In part, district meetings were established because of the rigors of travel in earlier days and they gave members an opportunity to convene for mutual information and benefit when Indianapolis was far away. The attraction of the district meeting waned gradually until recent years when they again became an important forum and a real factor in state medical association affairs. I would urge that we keep them that way.

JOHN O. BUTLER, M.D.  
*Trustee*

### Eighth Trustee District



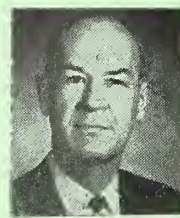
RICHARD INGRAM, M.D.  
*Trustee*

The Eighth District Medical Society had its annual meeting on Wednesday, June 7, at the Anderson Country Club. In attendance were a large number of physicians from all of the four counties represented in the Eighth District. Elections were held during the business meeting, at which time Dr. David Dietz of Muncie was elected Eighth District Medical Society President, Dr. Arthur Jay, also of Muncie, was elected secretary-treasurer of the Eighth District Medical Society. Further elections during that meeting included elections for trustees of the Eighth District. Dr. Richard Ingram was re-elected for another three year term, and Dr. Jack Alexander of Muncie was elected to fill the remainder of the unexpired term of Dr. R. B. Williams of Anderson, who had resigned his position. Other discussions were held during the business meeting but no other official business was transacted.

During the social and dinner hour the Eighth District Medical Society had as its honored guest Dr. Otis Bowen of Bremen, who talked with most of the guests personally, and later, following dinner, gave a very pleasant and instructive talk on the tax structure of the State of Indiana. It was felt that all benefited from his talk and enjoyed it as well. Fellowship was excellent and we are looking forward to a good meeting next year.

RICHARD INGRAM, M.D., *Trustee*

### Ninth Trustee District



WILLIAM M. SHOLTY,  
M.D.,  
*Trustee*

After two years as Ninth District Trustee, I am more and more aware of the workings of the ISMA and its struggle to maintain the freedom of medical practice as we have known it in the past. Socializing pressures come from many directions.

The Ninth is the largest district, composed of 12 counties. As a result of my political activity in the primary election I was not able to visit all of the societies. I plan to visit each in the near future.

The Ninth District meeting was held on June 28 at the Ulen Country Club in Lebanon. Dr. Don Boyer served as president and Dr. Clarence Kern served as secretary. Dr. Peter Petrich, ISMA President, Dr. James Gosman, ISMA president elect, Mr. James Waggener, Executive secretary, and Mr. Howard Grindstaff, were in attendance. Due to an almost all-day rain, the attendance was down.

The afternoon program was given by Dr. Guy Owsley, Dr. Raymond Murray, and Dr. A. G. Popplewell. Dr. Owsley discussed Peer Review; Dr. Murray, HMOs; and Dr. Popplewell, Foundations.

At the business meeting Dr. Barton Bridge (Ninth District Blue Shield Board member) and Mr. Gary Miller discussed the problems of Blue Shield. Dr. Bridge urged all physicians to bring their Blue Shield problems to him.

Dr. Wemple Dodds of Crawfordsville was recognized as one of the founders of Blue Shield and one of the original members of the Blue Shield Board of Directors. When asked about their interest in forming Blue Shield, Dr. Dodds stated that a group of physicians from ISMA felt that a prepaid medical plan was needed for all patients. Yet, consideration to sponsor such a plan was turned down by some 33 insurance companies, and therefore they decided to form a plan of their own.

Dr. Lanning suggested that the ISMA Grievance Committee be referred to as the Public Relations Committee, in an attempt to better inform patients rather than have them seek legal advice.

Next year's meeting will be hosted by the Fountain-Warren County Medical Society.

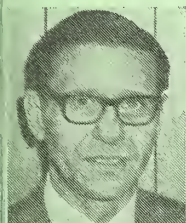


We again plan to have a delegates dinner meeting prior to the ISMA annual meeting to discuss resolutions to be presented.

I want to thank my counties for their interest and cooperation. As trustee, I am aware of the tremendous struggle medicine must wage in order not to become completely socialized.

WILLIAM M. SHOLTY, M.D.  
*Trustee*

## Tenth Trustee District



VINCENT J. SANTARE,  
M.D.,  
*Trustee*

The 10th District now consists of two counties, Lake County and Porter County. Lake County revised its constitution and by-laws so that its officers will now hold terms of two years. Dr. D. T. Ramker was elected president for 1972-1973, Dr. Mitchell Goldenberg was elected vice-president and Dr. R. J. Bills was elected secretary. The Lake County Medical Society is electing its officers, trustees and delegates by ballot election which is being presented in the fall for the election in October for the offices to be assumed in January.

Meetings of the Lake County Medical Society were well attended as well as the 10th District meeting.

In Porter County, Dr. John Forchetti was elected president and Dr. Alfred J. Kobak was elected secretary. The Porter County Medical Society has set up a non-profit trust in order to collect monies and to distribute monies to the families of doctors who either, because of illness or death, are in financial difficulty.

Both County Medical Societies are active in comprehensive health planning and have officers serving on the Executive Committee.

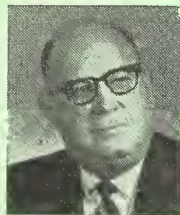
The 10th District has elected Dr. Martin O'Neill of Valparaiso to succeed Dr. T. C. Tyrrell of Hammond as alternate trustee for the 10th District. Dr. Tyrrell did not run for re-election since he felt that he has held sufficient offices that it would be better for the welfare of the District to have an additional person serving as alternate trustee. Dr. William Fitzpatrick was elected director to the Blue Shield Board in the place of Dr. S. W. Shapiro.

The 10th District meeting, held in Hebron at the Lakes of the Four Seasons, was well attended and officers of the state association, Drs. Petrich, Gosman, Harshman, Senseny, and Mr. Waggener attended. Dr. Edward R. Annis gave the talk at this meeting.

The dues for the 10th District were raised an additional \$2.00 a year in order to be able to finance better district meetings in the future.

VINCENT J. SANTARE, M.D.  
*Trustee*

## Eleventh Trustee District



LOWELL J. HILLIS, M.D.  
*Trustee*

The annual meeting of the Eleventh Trustee District was held at the Mississinewa Country Club, Peru, on September 15, 1971.

This was one of the most outstanding meetings that has ever been held in this district. The afternoon discussion groups were well attended and there was active participation in the discussion by the members present.

The business meeting resulted in the election of Dr. John Elleman of Kokomo as president, Dr. Fred Poehler, LaFontaine as secretary-treasurer, and Dr. James Harshman as alternate trustee.

A beautiful steak buffet dinner was served and then was followed by the speaker, Dr. Edward Annis, Miami, Florida, past president of the American Medical Association and past president of the International College of Surgeons.

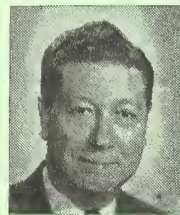
The speaker gave his usual presentation concerning the private practice of medicine. The evening program was broadcast live by radio station WSAL, and the tape was replayed later by stations WSAL-Logansport, WKMO-Kokomo and the Peru-Wabash radio station.

There have been no other activities within the district.

Great plans are again being made for the next district meeting September 20, 1972, at Kokomo.

LOWELL J. HILLIS, M.D.  
*Trustee*

## Twelfth Trustee District



WM. R. CLARK, SR.,  
M.D.,  
*Trustee*

During the past year I have met with some of my various Counties but have relied chiefly in relaying the happenings at the state level by editing a synopsis of the state trustees' meetings and having this report posted in the various Ft. Wayne and county hospitals. Not only were the state trustee meetings events posted but also other reports of other medical meetings I attended. It seemed that in this way I could better inform each county society of the current monthly happenings.

These reports I personally went over with the Ft. Wayne Medical Society Board of Trustees at their monthly meetings. This, along with the postings in my Counties, has proven very effective in getting quickly to each District Member the solutions of the problems presented to the state board of trustees. I have urged that all members of ISMA peruse the reports of the ISMA Newsflash and the Journal.

We have had three meetings of the Executive Board that was established by the mandate of our new, recently adopted Constitution. These meetings, too, have proven effective in solving some of the Districts' problems.

This is the first year that we have tried having the Annual District Meeting in September. It is felt that having the Annual Meeting at this time would promote better attendance, in that it would not conflict with other District meetings, thereby giving a chance for more of our state officers to attend and doing away with the lame duck period of the elected trustee and alternate trustee.

This report is being written prior to the September 14 Annual Meeting, at which time officers will be named. Dr. Annis will be the guest speaker and we look forward to a fine and well-attended meeting.

I will continue to work for the best interests of organized medicine trying to give better patient health care and improving our professional image.

WILLIAM R. CLARK, SR., M.D.  
*Trustee*



## Thirteenth Trustee District



**G. BEACH GATTMAN, M.D.,**  
Trustee

The Thirteenth District Medical Society of the Indiana State Medical Association held its Annual Meeting at the Continuing Education Building on the campus of Notre Dame University, South Bend, Indiana on September 8, 1971. An afternoon program on National Health Insurance-Medicredit was only moderately attended.

The business meeting was called to order by Dr. George Haley, President. Thirty-seven members were present. Dr. Otis Bowen, Thirteenth District Trustee gave his report, which included a comment on the lack of attendance at committee meetings. New officers elected were: Frank McGue, M.D., president (Michigan City); James Rimel, M.D., president-elect (Plymouth); David Spaulding, M.D., secretary-treasurer (Mishawaka); G. Beach Gattman, M.D., trustee (Elkhart); and Donald Chamberlain, M.D., alternate trustee (South Bend).

The dues of the Thirteenth District, which had been raised two years ago to \$2.00 per physician, seem to be adequate at the present time and it was decided to continue with the same dues.

Dr. Malcolm Scamahorn, President of the ISMA, attended as our guest.

Following cocktails and dinner, Mr. William Roose, Director of Drug Control, Indiana State Board of Health, spoke on "The Hoosier Drug Scene."

I have had the pleasure of attending the Christmas dinner meeting and dance of the LaPorte County Medical Society, and Dr. Chamberlain and I attended a joint meeting of the Starke-Pulaski County Medical Society at which Dr. Peter Petrich, president of the ISMA, gave the main address.

The officers of the District have been working on this year's District meeting and hope that the attendance will show a marked improvement.

**G. BEACH GATTMAN, M.D.,**  
Trustee

## Editor of The Journal

The financial accounts of *The Journal* this year will be approximately in balance with the budget. Some budget items will be long and others will be short,

with the totals very close to standard figures. The advertising revenue for the first six months of 1972 is five percent above that for 1971.

The establishment of the Mary Rogers Fund within the Indiana Medical Foundation has been generously supported by gifts in memory of Mrs. Rogers who worked as editorial secretary for *The Journal* for many years. The income from this source was utilized this year to aid in the reproduction of the brush painting by Dr. Wei Ping Loh for the July issue cover.

Special issues consisted of the Veneral Disease Program in November 1971 and the celebration of the 50th anniversary of the first clinical use of insulin in Indiana in the August issue this year.

A new feature was introduced in the form of a regular column on drug interactions. This is written by members of the faculty of Butler University College of Pharmacy through the cooperation of Dean K. L. Kaufman.

Medical history was recorded during the year in the form of a special issue which outlined the early medical history of Vincennes and Knox County, and by the account of the first use of insulin in this state in 1922.

Contributions, in the form of scientific and special articles, have been adequate and even generous, during the year. Acceptable scientific articles have been numerous enough to lengthen the time interval between acceptance and publication to a few months more than the customary six months. Additional revenue in the future will shorten the waiting period.

**FRANK B. RAMSEY, M.D.**  
Editor

## Delegates to AMA

The Indiana delegation to the American Medical Association's Annual Convention in San Francisco June 18 through 22 met long hours both during sessions of the AMA and after hours, to represent Indiana's physicians.

House of Delegates met for 17 hours and 20 minutes to act on 59 reports and 130 resolutions. These hours, of course, do not include the additional ones spent in reference committee meetings and caucuses of the delegation to consider the affairs of the national organization.

President Peter R. Petrich and President-Elect James H. Gosman met with the delegation throughout the four-day meeting. Chairman of the delegation was Dr. Eugene F. Senseny of Fort Wayne.

Delegates present were Drs. Frank H.

Green, Rushville; James A. Harshman Kokomo; Jack E. Shields, Brownstown and Lowell H. Steen, Hammond.

Alternate delegates attending included Drs. Patrick J. V. Corcoran, Evansville; A. Alan Fischer, Indianapolis; Kenneth O. Neumann, Lafayette; Eugene S. Rifer, Van Buren, and Thomas C. Tyrrell Hammond.

Also meeting in caucuses with the delegation were Drs. Guy A. Owsley, Hartford City, chairman of the AMA Council on Medical Service, whom the delegation nominated for vice president of the AMA; Myron H. Nourse, Indianapolis, delegate from the AMA Section on Urology; Lall G. Montgomery, Muncie, Section on Pathology, and Sprague H. Gardiner, Section on Obstetrics and Gynecology.

Among highlights of the meeting was the election of Dr. Russell B. Roth, speaker of the House, to the president-elect post of the AMA.

Other actions included approval of representation for medical students in the House of Delegates. In addition, results of the first AMA membership poll were presented to delegates—showing an overwhelming number of physicians endorsing AMA efforts to retain the basic principles of private practice in any government health program that might be enacted.

In his inaugural address, Carl A. Hoffman, president of the AMA, told the House of Delegates: "The cry for unionism is being raised in our profession as never before. There is no doubt that trade unionism has been an effective and valuable social instrument in our nation. But is it a proper activity for physicians to engage in?"

It is not, Dr. Hoffman said, because "unionism seeks its objectives through group power—and it achieves its power by carefully controlled conformity.

"This is the very objection we as a profession have raised against government-controlled medicine. The source of power of unionism lies in its ultimate weapon—the strike. A strike, even the threat of a strike, is a threat to withhold services. It is, therefore, a violation of medical ethics.

"Cynics may scoff, but millions of Americans still do enjoy a close personal relationship with their physicians," Dr. Hoffman declared.

On other matters, Dr. Hoffman said, "Peer review is an idea whose time has come. With the acceptance of the third party payor system, we accepted the ultimate necessity for certain controls by those who pay the bills. It is in the pub-



ic interest—and in our own interest—to develop a flexible mechanism that is credible to the public, and does not lower the dignity of the profession. . . . Peer review was initiated by the profession itself.”

Concluding, Dr. Hoffman addressed himself to younger members of the House and to new physicians in general. He said he believed in years to come they would find that “this association alone represents American medicine.” And as our society becomes more complex and the government larger, “there is an even greater need for institutionalized power outside of government,” he said.

The House received, and adopted, results of the first membership opinion poll on critical issues affecting the practice of medicine. The overwhelming majority of 94,000 respondents (73.1%) recommended that AMA continue to seek to retain the basic principles of private practice in any government enacted health program. And more than half (55.7%) preferred the AMA plan of national health insurance over all others. The AMA plan was four times as acceptable as the next most preferable option, which was catastrophic coverage only (14.1%). If compulsory health insurance were adopted, 28.1% of respondents said they would continue private practice “with those patients who would pay my private fees” and 24.6% said they would “join the federal program and continue to practice under it.” Many (21.6%) were undecided as to what they would do.

On the work of the Association, programs which received the greatest percentage of responses indicating “not enough” emphasis were: communications to the public (62.5%); practice management problems (39.8%) and socioeconomic issues (35.1%). A majority of members indicated that AMA was placing “proper” emphasis on: scientific activities (66.3%); medical education (67.9%); continuing education (63.3%); membership benefits (51.8%) and communication to the medical profession (55.2%).

The questionnaire went to 177,882 non-federally employed members and 94,035, or 52.9%, questionnaires were returned. The questionnaire also was sent to a random sample of 4,500 members, including federal physicians, and a ran-

dom sample of 3,000 non-members of the AMA to test sampling techniques as a possible tool for use in future surveys.

Reflecting concern for “potential problems which could arise,” the House approved a policy opposing employment of physicians’ assistants in hospitals. The move was recommended by the Council on Health Manpower and the Board of Trustees, through Board Report B.

Also adopted was Board Report Z, proposing guidelines for compensating physicians for services of physicians’ assistants. It urged legislation to empower state boards of medical examiners to approve a physician’s employment of an assistant and to approve proposed functions of the assistant, as described by his employer. Reimbursement for assistant’s services should be made directly to the employing physician, the report said.

Also adopted was Board Report F, dealing with education and utilization of allied health manpower. Some of its recommendations urged AMA to:

1. Continue to support efforts to increase the number and improve the utilization of medical, nursing and allied personnel until 1975, with re-evaluation then on the need for further efforts.

2. Continue to support improvement of the professional and financial potential of allied health careers.

3. Continue efforts to expand allied health career opportunities for minority and disadvantaged groups.

4. Strongly reaffirm support of an expanded role for the nurse in providing patient care, and study the nurse’s role in relation to the physician assistant, so the two professions can complement rather than duplicate one another.

The House refused to accept the statement in Board Report J which said, “possession of marihuana for personal use and transfer (not sale) of insignificant amounts should not be criminal acts.” After extensive debate, this substitute recommendation was adopted:

“This AMA House of Delegates does not condone the production, sale or use of marihuana. It does, however, recommend that the personal possession of insignificant amounts be considered at most a misdemeanor with commensurate penalties applied.”

The substitute recommendation continued (in agreement with the original): “(The House) also recommends its prohibition for public use; and that a plea

of marihuana intoxication should not be a defense in any criminal proceeding.”

Delegates approved a strong resolution aimed at any independent determination of customary physicians’ fees:

“Resolved, that where benefits include physicians’ fees, management, labor and third party carriers shall consult with duly constituted representatives of organized medicine before determining ‘usual, customary and reasonable fees,’” the measure said.

The resolution was adopted in lieu of several others, all protesting actions of Aetna Life and Casualty Insurance Company. It added:

“The medical profession will not condone or tolerate action on the part of any third party that would encourage or promulgate litigation in the settlement of any such dispute.” This referred to a practice of telling policy holders that—except where there was prior agreement between patient and physician as to the fee—the insurance company would pay the patient’s legal costs if the physician sued to collect his full fee.

The resolution also reminds physicians “that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered.”

The House approved acceptance of a new contract with the Fireman’s Fund Insurance Co. to continue the AMA Group Disability Insurance Program (Board Report M). The contract is to run five years, ending Sept. 1, 1977, although the program is not guaranteed beyond Sept. 1, 1974. There will be no increase in premium, but benefits will be reduced by 50 per cent from age 65 through 69, and an additional 50 per cent at age 70, remaining at that level for life. The amount of benefits payable for accidents will be reduced the same as sickness benefits. The Board said Fireman’s Fund insisted on the change and that no alternate carrier could be found.

Paul Dudley White of Boston, internationally famed heart specialist, received the fifth annual Sheen Award (including a check for \$10,000) for outstanding contributions to medicine.

JAMES A. HARSHMAN, M.D.

EUGENE F. SENSENY, M.D.

FRANK G. GREEN, M.D.

JACK E. SHIELDS, M.D.

LOWELL H. STEEN, M.D.



# Reports of Committees

## Executive Committee

The Executive Committee met for organization purposes upon the conclusion of the meeting of the Board of Trustees following the final session of the House of Delegates on October 14, 1971.

At that time Dr. Donald Kerr was by secret ballot elected chairman of the committee and Dr. James H. Gosman was welcomed as a new member of the committee by virtue of being elected president-elect of the Indiana State Medical Association.

The committee met again on November 13, 1971, at which time they received a report from the federal government complimenting the handling by the ISMA of the CHAMPUS program.

The committee heard a report from the Woman's Auxiliary concerning their proposed Nursing Home Visitation program and this matter was referred to the Board of Trustees.

The committee referred material concerning foundations to the Future Planning Committee with the request that they make a thorough investigation of foundations and make their recommendations to the Association.

As a result of the survey of the membership, the committee received information from the IMMKE Leasing Company concerning a car leasing program for members of the Indiana State Medical Association and this was referred to the Board of Trustees.

Matters relating to Blue Shield were discussed.

The dates for the 1972 meeting were finalized with recommendation that the meeting be held at the Convention Center, which was also named as the Headquarters for the 1972 meeting.

The committee approved the purchase of the Chamber of Commerce Legislative Reporting Services to be used by the staff and the Commission on Legislation.

A release prepared by the Headquarters staff was approved for use by the Fayette-Franklin Medical Society in case the county society desired to use it.

Several matters dealing with the 1971 Clinical Session of the American Medical Association were also reviewed.

The committee heard a presentation by Dr. Bonsett concerning the transformation of the old Pathology Building

on the Central State Hospital grounds as a Medical Historical Center and a Museum for early Indiana Medicine. This matter was referred to the Board of Trustees to determine if the Indiana State Medical Association would be interested in participating in this effort.

The committee also heard a presentation by Mrs. Chernish, president of the Woman's Auxiliary, concerning the installation of a kitchen facility in the building, and this was referred to the Board of Trustees.

The committee convened again on December 15th and received a report from the AMA meeting that interns and residents would be expected to pay an additional \$20 in dues if they desired to belong to the AMA. It was taken that we would not bill for the '72 dues in view of the fact that billings had already been mailed, but the secretary was instructed to inform interns and residents they could join the AMA by paying an additional \$20 if they so desired.

A report from the Commission on Voluntary Health Agencies requesting that the Yearbook issue list only the Voluntary Agencies which had been approved by the Commission was accepted.

The committee planned for a joint meeting with representatives of the osteopathic association to be held in January of 1972.

Membership in the Better Business Bureau was renewed.

Membership in the Indiana State Chamber of Commerce was also renewed.

A letter of approval from Dr. Offutt concerning the proposed Visitation of Nursing Homes Program by the Auxiliary was reviewed and the Visitation Program was then approved by the committee.

Minutes of the Blue Cross and Blue Shield Boards were reviewed.

The committee heard a report from the executive secretary that the expense of holding the meeting at the Convention Center would in all probability exceed those paid formerly in the occupation of the Murat Temple.

The committee approved a proposed bill concerning Health Careers and also approved distribution of a bibliography of publications dealing with Service Systems for Delivery of Health Care.

Representatives were selected by the committee for various meetings to be held by the AMA and other organizations in which the committees of the Association would have a vital interest.

The committee was visited by representatives of a county medical society

for a discussion of a lawsuit which had been instituted against several physician members of that society.

The committee then met with representatives of the Indiana Nurses Association, the optometric association and the pharmaceutical association for a discussion of a proposed bill to certify physicians' assistants.

The next meeting of the Executive Committee was held on January 8, 1972, and the committee again heard a presentation by Doctor Bonsett and again this was referred to the Board of Trustees.

The committee approved the purchase of dishes for the kitchen by the Auxiliary.

A proposal for a tour by members of the Association was reviewed and it was ordered sent to the legal counsel for legal opinion before signing.

Welfare matters concerning the decertification of some Indiana physicians as providers under Title XIX Act was reviewed and a letter from the Welfare Director addressed to the Indiana congressional delegation expressing dissatisfaction with the handling by HEW of Title XVIII and XIX programs was reviewed and the committee voted to commend Mr. Sterrett on his letter.

The committee took action to recommend that Reference Committees also be titled so as to indicate the type of business which would be considered by them and also voted to recommend to the Board of Trustees that they submit a resolution to the 1972 House of Delegates requiring fiscal notes be attached to all items calling for expenditure of association funds.

It was also voted to recommend to the Board of Trustees that a resolution be prepared to give the medical students a vote in the House of Delegates.

The next meeting of the Executive Committee was held on March 4th. The committee received requested changes in the Bylaws of the Indiana Medical Assistants organization and the changes were approved.

The committee voted to assist the SAMA organization of Indiana by a contribution to help defray the expenses of their delegates to their national meeting.

The attorneys' opinion concerning the doctor's liability in the Consumer Code was reviewed.

The committee received a report from the Commission on Emergency Medical Services of a proposed policy statement on the training of emergency medical personnel and this was referred to the Board of Trustees with the recommendation that it be approved.



The committee voted to recommend that Dr. J. O. Ritchey be nominated to receive the Sheen Award.

Plans for the promotion of the candidacy of Dr. Guy A. Owsley for vice president of the American Medical Association were reviewed.

A request from Blue Shield for revising member fees for the physicians' program was reviewed and referred to the Board of Trustees.

An attorney's opinion concerning the liability of a physician in the drawing of blood under Indiana's implied consent law was reviewed and the secretary was instructed to distribute this information widely.

The secretary reported that, as suggested, he had received bids for the printing of *The Journal* and the committee voted to refer this to the Board of Trustees with the recommendation that the Journal be printed by the Gibbs-Inman Company of Louisville, Ky., beginning with the July issue.

The committee set up the guidelines for operation of the Indiana room at the San Francisco meeting of the AMA.

The committee met again on April 6th.

A letter was received from the Vanderburgh County Medical Society withdrawing their request for holding the 1974 annual meeting in Evansville. The letter was accepted.

The committee reviewed a tentative program for the joint meeting of the Indiana Hospital Association and the Indiana State Medical Association for hospital administrators, chiefs of staff and trustees.

The committee voted to increase the limit on travel insurance for commission and committee members and officers of the association traveling on business of the association, the limit to be increased from \$50,000 to \$100,000 for accidental death or dismemberment.

Membership in the U. S. Chamber of Commerce was renewed.

Blue Cross-Blue Shield coverage of association employees was renewed.

A letter was received from the A. H. Robins Company together with a check for \$200 to be used as the Indiana State Medical Association saw fit in development of professional or scientific matters and the matter was referred to the Board of Trustees for acceptance or rejection.

The guest list for the 1972 annual convention was approved.

The committee discussed the use of the Medical Defense Fund and it was voted to suggest to the Board of Trustees

that they present a resolution to the House setting a top limit of \$2,000 per case.

The committee convened again on June 10, 1972.

The contract for the charter trip to the Orient was approved and signed.

The secretary discussed the remodeling of the office space in the headquarters building and presented bids for the work. The secretary was instructed to proceed and the lowest bid was accepted.

The secretary reported he had received an overture from the Regional Medical Planning group to use Indiana State Medical Association's field staff jointly with the RMP and that possibly funds would be available from RMP to employ additional field staff. The Executive Committee approved this proposal and referred it to the Board of Trustees.

The secretary raised a question concerning Chapter 4, Section 2 of the Bylaws concerning delegates to the state convention and this matter was referred to the Board of Trustees.

The committee heard a complaint from a physician concerning the election held by the Fourth District Medical Society and this was taken as a matter of information.

The secretary presented a pamphlet entitled "Misconceptions of Medicare" developed by the Illinois State Medical Society with permission to reproduce it. The idea of duplicating this for use by Indiana physicians was approved and referred to the Board of Trustees.

The secretary raised a question concerning military members and this matter was referred to the Commission on Constitution and Bylaws.

The committee voted to send information to the newly appointed Building Committee that they plan now for the expansion of the existing building.

The audit of the Medicaid operation by the Legislative Council was called to the attention of the committee.

The secretary presented an opinion from the attorneys on the subject of usual and customary fees.

A court decision of the Missouri Supreme Court was read which might have the effect of declaring all doctors in violation of the Missouri law in the use of medical assistants or other type of ancillary personnel.

Opinions were expressed at the request of the Legislative Advisory Committee concerning a proposed law dealing with physicians' assistants and ancillary personnel.

At the request of Oscar Ritz, state

insurance commissioner, an association representative was named to represent ISMA on a committee for the study of HMOs.

The above are merely a few of the matters which came before your Executive Committee and complete copies of all the minutes are in the hands of the Reference Committee for their review.

In addition, the committee reviewed the financial situation of the association at each of its meetings, as reported by the treasurer, as well as the membership report and the requests for medical defense by physicians who have been sued for malpractice.

Reports on Medical Defense activities, *The Journal* and the Membership Report are as follows:

### Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1, 1971, the following two cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date, \$1,042.73)

Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1971 and to August 1, 1972, three new cases have been filed.

2. Medical Defense Fund Statement from August 1, 1971, to August 1, 1972:

Bank balance,	
August 1, 1971	.....\$8,175.35
Receipts	.....8,787.76
Total cash and receipts	
August 1, 1972	....\$16,963.11
Disbursements	.....None
Balance on hand	
August 1, 1972	....\$16,963.11

### The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1972, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116



The table below shows the total printing costs of *The Journal*

Year	Total Printing Cost	No. of Pages (Inserts Excluded)
1967	\$49,958.15	1450
1968	50,709.62	1462
1969	42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972 (6 mos.)	22,051.53	716

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1972, is as follows:

State	1968	1969	
Medical	*24,153.24	17,086.59	
Journal Adv.	**7,200.10	2,557.80	
Bureau*	31,353.34	19,644.39	
	1970	1971	1972
Sold direct	15,791.12	13,128.30	17,869.96
by Journal**	2,268.80	1,821.89	1,622.60
Totals	18,059.92	14,960.19	19,492.56

MEMBERSHIP REPORT

Total Members	December, 1970	December 1971	
ISMA	4,505	4,554	
AMA	4,337	4,293	
	July 31, 1971	July 31, 1972	
ISMA	4,489	4,526	+37
AMA	4,236	4,179	-57

DISTRICT REPORT AS OF JULY 31, 1972

+ GAIN - LOSS	ISMA	AMA
DISTRICT		
1	+ 4	- 3
2	+ 2	+ 1
3	+15	+11
4		-10
5	- 5	- 7
6	+ 2	- 3
7	+17	- 9
8	+16	+ 1
9	+ 3	- 2
10		- 2
11	- 3	- 7
12		- 5
13	-14	-22
	+37	-57

TOTAL NEW MEMBERS

DISTRICT	AS OF JULY 31, 1972
1	8
2	4
3	20
4	10
5	5
6	5
7	32
8	14
9	5
10	29
11	10
12	10
13	12
	164

DEATHS

December, 1971	As of July 31, 1972
54	30

MEMBERSHIP REPORT

	Dec. 31, 1971 ISMA	July 31, 1971 ISMA	July 31, 1972 ISMA	July 31, 1972 AMA
1st DISTRICT				
Gibson	11	11	11	11
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	5	5
Vanderburgh	259	251	256	242
Warrick	7	7	6	6
TOTAL	297	289	293	279

2nd DISTRICT				
Daviess-Martin	18	17	18	11
Greene	16	16	16	10
Knox	39	39	41	40
Owen-Monroe	91	88	89	80
Sullivan	12	12	10	9
TOTAL	176	172	174	150

3rd DISTRICT				
Clark	48	47	53	47
Dubois	27	27	26	22
Floyd	45	45	44	44
Harrison-Crawford	9	9	9	9
Lawrence	29	28	37	29
Orange	7	7	8	8
Scott	5	5	7	7
Washington	8	8	7	6
TOTAL	178	176	191	172

4th DISTRICT				
Bartholomew-				
Brown	56	56	61	49
Dearborn-Ohio	17	16	15	14
Decatur	13	13	10	9
Jackson-Jennings	21	21	19	18
Jefferson-Switzerland	29	29	29	23
Ripley	10	10	11	9
TOTAL	146	145	145	122

5th DISTRICT				
Clay	13	13	10	10
Parke-Vermillion	17	17	15	15
Putnam	19	19	18	18
Vigo	119	118	119	115
TOTAL	143	167	162	158

6th DISTRICT				
Fayette-Franklin	15	15	16	16
Hancock	27	27	27	27
Henry	38	38	38	33
Rush	13	13	12	12
Shelby	21	20	21	17
Wayne-Union	71	69	70	63
TOTAL	185	182	184	168

7th DISTRICT				
Hendricks	23	23	22	18
Johnson	36	36	36	34
Marion	1081	1057	1075	1047
Morgan	21	21	21	19
TOTAL	1161	1137	1154	1118

8th DISTRICT				
Delaware-Blackford	125	119	128	101
Jay	16	16	16	13
Madison	102	101	108	75
Randolph	17	17	17	13
TOTAL	260	253	269	202

9th DISTRICT				
Benton	9	9	10	9
Boone	17	17	18	18
Clinton	14	14	14	11
Fountain-Warren	11	11	11	10
Hamilton	16	16	14	10
Jasper	8	8	8	8
Montgomery	21	21	22	22

Newton	5	5	5	5
Tippecanoe	150	148	142	132
Tipton	11	11	11	11
White	7	7	7	6
TOTAL	269	267	262	242
10th DISTRICT				
Lake	456	447	450	414
Porter	64	62	67	65
TOTAL	520	509	517	479
11th DISTRICT				
Carroll	8	8	8	8
Cass	39	38	35	29
Grant	76	76	79	78
Howard	70	70	70	68
Huntington	19	19	18	17
Miami	13	13	13	12
Wabash	31	31	29	22
TOTAL	256	255	252	234

12th DISTRICT				
Adams	13	13	12	12
Allen	311	310	311	283
DeKalb	20	20	19	15
LaGrange	11	11	11	9
Noble	12	12	12	12
Steuben	10	10	10	10
Wells	39	39	40	40
Whitley	15	15	15	15
TOTAL	431	430	430	396

13th DISTRICT				
Elkhart	113	111	111	102
Fulton	6	6	7	6
Kosciusko	14	14	12	12
LaPorte	98	97	93	78
Marshall	25	25	20	18
Pulaski	4	4	5	1
St. Joseph	243	242	237	235
Starke	8	8	8	7
TOTAL	511	507	493	458

SUMMARY

1st DISTRICT	297	289	293	279
2nd DISTRICT	176	172	174	150
3rd DISTRICT	178	176	191	172
4th DISTRICT	146	145	145	122
5th DISTRICT	168	167	162	158
6th DISTRICT	185	182	184	168
7th DISTRICT	1161	1137	1154	1118
8th DISTRICT	260	253	269	202
9th DISTRICT	269	267	262	242
10th DISTRICT	520	509	517	479
11th DISTRICT	256	255	252	234
12th DISTRICT	431	430	430	396
13th DISTRICT	511	507	493	458
	4,558	4,489	4,526	4,179

DONALD M. KERR, M.D., Chairman  
WILBERT McINTOSH, M.D.  
PETER R. PETRICH, M.D.  
JAMES H. GOSMAN, M.D.  
JOSEPH DUKES, M.D.  
LESTER H. HOYT, M.D.  
HUGH K. THATCHER, JR., M.D.

Grievance Committee

The Grievance Committee met on November 21, 1971, and July 9, 1972. Few complaints were received, which is an indication to the committee that the county medical societies are doing a better job in handling complaints at the local level and they are to be commended for this. The two most prevalent complaints received by the committee are those of a misunderstanding of charges by physicians and the lack of communication between the patient and the doctor.

As of August 1, 1972, 10 new cases



were filed, three of which have been referred to the local county medical society. Eight complaints were received in which no authority was given by the complainant to forward a copy of the complaint to the physician named.

As mandated by the 1967 House of Delegates, the Purposes, Rules and Procedure of the Grievance Committee has been revised and was printed in the January 1972 *Journal* of the ISMA.

We wish to call attention to the Grievance Committee recommendations of the St. Joseph County Medical Society which will help avoid grievances. Our committee felt these recommendations should be published in *The Journal* and we wish to incorporate them in the annual report of the House of Delegates.

1. Do not charge for calls unless they are actually made by the physician or his substitute.

2. When a substantial charge is made for service, such as a foot strapping, injection of bursa, application of cast, etc., we would suggest that the charge cover the office call as well as the particular service rendered, rather than to submit an additional charge for the office call.

3. The surgeon should not charge for postoperative hospital visits up to a reasonable limit, if they are part of the normal care. Neither should the attending or referring man make charges unless there is an actual medical problem to be managed.

4. If procedures are likely to require charges which would seem excessive to patients, discussion of the procedure and the fee for such would be appropriate to avoid misunderstandings. This involves surgical procedures, special procedures by medical specialists and by anesthesiologists. Furthermore, if certain procedures will require a long anesthetic, the patient might be forewarned, so that he may anticipate an appropriate charge for the anesthesia.

5. The need for hospitalization should be verified by the physician before he admits the patient to the hospital.

6. Communication breaks have created problems resulting from:

- (a) Refusal to itemize statements.
- (b) Refusal to communicate with patient by letter or by phone.
- (c) Discourteous conduct toward patients, including refusal to review materials submitted by patients, discussion of patient in front of nurses, careless discussion of patients on ward rounds while in the presence of the patient, failure to inform

patient of diagnosis and to give appropriate advice, and inappropriate discharge of patients from hospital before the patient is adequately informed of the diagnosis and followup measures.

- (d) Unwillingness to discuss fees with patients when requested.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility.

JOHN M. PARIS, M.D.,

Chairman

KENNETH WILHELMUS, M.D.,

Secretary

WALLACE R. VAN DEN

BOSCH, M.D.

KENNETH L. OLSON, M.D.

WILLIAM D. PROVINCE, M.D.

EUGENE S. RIFNER, M.D.

RICHARD S. BLOOMER, M.D.

ROBERT G. YOUNG, M.D.

## Future Planning Committee

Your Future Planning Committee has met on several occasions and submits the following report for consideration of the House of Delegates.

After extensive discussion, the Future Planning Committee recommends that all county medical societies extend their efforts to assure that every physician in every county in Indiana become a member of ISMA and the American Medical Association. Whatever steps are necessary to recruit these individuals should be taken to broaden our physician participation. Particular attention was given to ISMA non-membership of the faculty of the Indiana University School of Medicine. President-elect James H. Gosman, M.D., indicated that he would make this a personal crusade.

In view of growing changes in the military medical dependents' program, it is probable that the Indiana State Medical Association may be called upon to process an increasing number of claims under the CHAMPUS program. Also, the Indiana State Medical Association is constantly expanding its many programs and services, most notable of which is the increased use of the facilities by various special societies. The Future Planning Committee can foresee a time when a need for additional space will become critical. It was therefore, recommended that the president appoint a building committee to begin investigation and discussion of future expansion of the headquarters facilities.

Foundations were discussed and, by

unanimous consent, it was agreed to recommend to the Board of Trustees of ISMA that the Indiana State Medical Association establish a statewide foundation, on paper, if nothing else. Further discussion of this matter grew at the most recent joint meeting of the Committee on Future Planning and the Commission on Medical Economics and Insurance. (Please see joint report of the Commission and the Committee elsewhere in this issue.)

The Executive Secretary's report to the House of Delegates of the 1971 Convention was referred to the Future Planning Committee for discussion and recommendation. The Committee commends Mr. Wagener for the excellence and comprehensiveness of his report. As a result of this view the following actions were taken.

The Committee recommended to the Board of Trustees that they immediately give the Executive Secretary permission to employ one additional person for the purpose of handling legislation, government and public affairs and, further, it was recommended that the Committee felt even additional personnel would be needed in the very near future to fulfill the obligations of the Association to its membership, commissions and committees. We further recommended that the Board consider employment of an additional individual or two as soon as appropriate budgeting and financial arrangements could be accomplished to meet this manpower demand.

Attention was directed to the Medical Disciplinary Act that had been passed unanimously by the House of Delegates in 1970 and was held up by the Board of Trustees who had been unable to agree on some of the wording. The rewording was placed before the Delegates at the 1971 meeting; they approved the introduction of the legislation to the 1972 session. Subsequent to this, the Commission on Legislation took a position not to introduce the bill at this time and it was, therefore, not introduced. It was the feeling of the Future Planning Committee that such an act should have been placed before the 1972 session of the legislature to cure many of the problems of discipline among physicians in the State of Indiana. It was the unanimous opinion of the Future Planning Committee that this bill definitely be introduced to the 1973 session without hesitation or delay. It was reported that several legislators are extremely anxious to sponsor this bill on a bipartisan basis.



It is the opinion of the Future Planning Committee that suggestions for long-term change and suggestions which may be of long-term importance to the Indiana State Medical Association be forwarded to it by other commissions, committees, individual members and by our delegates and individual members of the Indiana State Medical Association. Submitted by,

LOWELL H. STEEN, M.D.,  
Chairman  
STANLEY CHERNISH, M.D.  
MAURICE E. GLOCK, M.D.  
JAMES FITZPATRICK, M.D.  
RALPH V. EVERLY, M.D.  
PATRICK J. V. CORCORAN, M.D.  
GEORGE M. HALEY, M.D.  
CHARLES GILLESPIE, M.D.  
LESLIE BAKER, M.D.  
MALCOLM O. SCAMAHORN, M.D.  
(ex-officio)  
PETER R. PETRICH, M.D. (ex-officio)  
DONALD M. KERR, M.D. (ex-officio)  
FRANK B. RAMSEY, M.D. (ex-officio)  
JOE DUKES, M.D. (ex-officio)

## Student Loan Committee

The Student Loan Committee did not have a formal meeting the past year. However, two telephone and letter meetings were held regarding the obvious default of one of the loans which, in due time, was resolved by the payment in full of the loan.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the Association has on deposit with the bank \$20,810 to guarantee loans totaling \$260,000. As of July 31, 1972, 108 loans totaling \$95,500 have been granted under this plan. During this year 31 loans have been converted to installment loans in the amount of \$30,971.00; one loan totaling

\$700 has not been converted; 17 loans have been paid in full during this year.

A report on the Loan Fund which was under the Association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	\$58,458.36
Total repaid by loanees as of	
July 31, 1972.....	58,386.60
Total amount outstanding,	
July 31, 1972	\$ 71.76
Of the 117 who received loans,	
116 have repaid in full	
1* is making payments	
*Total due on above loan still	
outstanding .....	\$ 71.76

As previously reported, two loans under the Guaranteed Loan Plan were defaulted, one in the amount of \$606.54 and the other, \$1,913. The Indiana National Bank was reimbursed for these notes. We wish to report that the Association has received \$754.28 from the estate of the physician whose loan was \$606.54, and regular payments are being received from the physician whose loan amounted to \$1,913.

The Student Loan Committee is surprised that there were no applications for loans from October 1, 1971, to July 31, 1972. Despite this fact, it is our feeling that the Student Loan Program does provide financial help to needy students. However, we know that low interest rate loans, no interest loans and federal grants are currently available to students.

MALCOLM O. SCAMAHORN, M.D.

Chairman

PETER R. PETRICH, M.D.

JOE DUKES, M.D.

JAMES O. RITCHEY, M.D.

LESTER H. HOYT, M.D.

GLENN W. IRWIN, JR., M.D.

## Joint Medical-Legal Review Committee

The Joint Medical-Legal Review Committee met March 15, 1972, with all medical and two legal members in attendance.

The committee has received no official complaints this year.

The amendment to improve the practical implementation of the inter-professional code has been approved by the House of Delegates of both the Indiana State Medical Association and the Indiana State Bar Association. The Code has since been reprinted in the Indiana State Medical Association's *Journal*. A large supply of reprints was obtained which the committee recommended should be distributed to new members and to grievance committee members of each association and, if possible, to the Judges in the State. The Indiana State Bar Association will reimburse the Indiana State Medical Association for those reprints it requires for its members.

We feel that the above measures will serve to better inform the membership of each association that the Joint Medical-Legal Committee is functioning and ready to hear complaints and, perhaps, will have a beneficial influence upon the conduct of members of both professions.

Dr. Beeler and Mr. Segar are planning to have a joint meeting between physicians and attorneys in Marion County, particularly, in an effort to come to a better understanding on the medical malpractice problems in this state, and they may extend an invitation to all members of both associations throughout the state.

JOSEPH WEBER, M.D.

Chairman

JOHN W. BEELER, M.D.

ROBERT R. KOPECKY, M.D.

MR. ROBERT WATERS (SAMA)

## Fifth Trustee District



WILBERT McINTOSH,  
M.D.,  
Trustee

The Fifth District Meeting was held on May 24, 1972, at the Terre Haute Country Club.

The meeting was called to order at 3:00 p.m., by the president. A panel

consisting of Doctors Guy A. Owsley, Raymond H. Murray, and Patrick Corcoran discussed utilization review, HMOs and foundations. This was a very informative discussion. Many questions were asked from the group.

Other visitors included Mr. Herb Dixon of Blue Shield, who discussed the up-coming annual meeting in October. Also present was Mr. James Waggener, executive secretary, and Mr. Robert Amick, field secretary. Mr. Amick made a brief report.

Doctor James H. Gosman, president-

elect was also present. After discussions by visiting dignitaries, an election was held. Dr. Cleon Schauwecker was chosen Trustee to replace Doctor McIntosh. Doctor William G. Bannon was elected alternate trustee to succeed Doctor Schauwecker.

The business meeting was adjourned at 5:00 p.m. A dinner was held at 7:00 after a cocktail hour. Dr. Otis Bowen was the principal speaker.

WILBERT McINTOSH, M.D.

Trustee



# Reports of Commissions

## Legislation

The commission on Legislation, under the chairmanship of Donald E. Wood, M.D., had its first experience of participating in the new interim meeting of the Indiana State Legislature when the 30-day session for even-numbered years and the Indiana Legislative Council were established.

Hearings on bills to be acted upon in the '72 session were assigned to committee early in November and hearings were held on a great number of bills which were prefiled and were available for immediate floor action upon the convening of the legislature on January 11, 1972.

At the first meeting of the Commission they discussed various bills. The Commission reviewed 21 bills in the Senate and 10 in the House. One of the bills that the ISMA Commission was interested in backing was one which created a method of certification and control of the physician assistant, which is fast becoming a reality in the practice of medicine. Due to pressure brought by some groups opposing this bill, the Commission had a meeting with the Executive Committee of the Association, the Indiana Nurses Association, the Indiana Pharmaceutical Association, and the Indiana Optometric Association. The meeting was for the purpose of attempting to resolve the opposition of these groups to the bill and to explain why the Association felt it necessary to have such a bill adopted by the legislature. In spite of this effort, the bill was lost and not adopted. There is no doubt that the creation of the medical assistant school by IU-PUI on the Fort Wayne campus will add still more reason for such a bill to be introduced in the '73 session.

In an effort to gain local understanding and support of the county medical societies, copies of several bills with an explanation were distributed and local physicians were encouraged to contact their representatives in the State Legislature.

The Commission also met with representatives of the State Department of Welfare and the Board of Medical Registration and Examination for a discussion of materials relating to these organizations.

All in all, during the course of the 30-day session the Commission would

up reviewing a total of 30 House bills and 26 Senate bills. Under the new arrangement there is no doubt that the Commission on Legislation will also be involved in the 12-months' activity as it prepares for the annual session of the State Legislature as well as reviewing materials to come before Congress.

Attendance at the meeting of the Commission was good and I, as chairman, wish to express my thanks for the cooperation of the members of our commission as well as the legislative representatives in the various county medical societies.

DONALD E. WOOD, M.D.,

Chairman

ROBERT E. ARENDELL, M.D.

ROBERT ROSE, M.D.

NELSON WOLFE, M.D.

LESLIE M. BAKER, M.D.

WILLIAM BANNON, M.D.

JOHN A. DAVIS, M.D.

JOHN PANTZER, M.D.

JACK L. ALEXANDER, M.D.

MAX N. HOFFMAN, M.D.

A. P. BONAVENTURA, M.D.

RICHARD L. GLENDENING, M.D.

DEWAYNE HULL, M.D.

HARRY STOLLER, M.D.

JAMES KIRTLEY, M.D.

DONALD TAYLOR, M.D.

JOSEPH BLACK, M.D.

JOSEPH McPIKE, M.D.

FRED POEHLER, M.D.

HARVEY SACKS (SAMA)

## Public Information

The Commission on Public Information met on four occasions during the calendar year 1972 to conduct routine business and to discuss special matters of importance to the Indiana State Medical Association.

*Awards Program.* Applications for newspaper, radio, and/or television awards which are presented annually by ISMA were screened, and a recipient was selected in each category by the Commission. Applications for the Physician's Community Service Award were also screened by the Commission and an award was made to be presented at the annual ISMA Convention.

*Waiting Room Display Kits.* The program for the dissemination of these kits was developed this year. After much work by this Commission on this program, the Board of Trustees of ISMA gave their approval to this program and a pilot project consisting of 1,000 of these kits will be distributed to fellow physicians of ISMA. This program will

be budgeted in the 1973 fiscal year and will be underway at the beginning of next year. It will be a continuing project of the commission.

*Physician Liability Booklet.* This booklet was developed by the Commission and patterned after one prepared by the Illinois Medical Association. The Board of Trustees of ISMA appropriated monies for this project in 1972, and this booklet will be ready for distribution to every physician in the state of Indiana in 1973.

*Physician Activity File.* A new project which was discussed and which will be promoted by the Commission is the updating and developing a computer-compatible physician activity file for use by the officers and staff of ISMA. Data on each physician member of ISMA is the goal of this project. Data thus secured could then be used by the officers and staff of ISMA to better use the many and varied talents of physicians throughout the State Medical Association.

There are no recommendations from this Commission to the House of Delegates of ISMA.

The Commission would like to publicly thank the officers and members of the staff of ISMA for their suggestions and help.

FRED DAHLING, M.D.,

Chairman

WILLIAM B. CHALLMAN, M.D.

THOMAS O. MIDDLETON, M.D.

LOUIS H. BLESSINGER, M.D.

KENNETH D. SCHNEIDER, M.D.

RICHARD S. BLOOMER, M.D.

ROBERT W. HARGER, M.D.

PAUL BURNS, M.D.

BARBARA BACKER, M.D.

HARRY G. BECKER, M.D. (At Large)

VICTOR JOHNSON, M.D. (At Large)

## Governmental Medical Services

During the course of the last 12 months the Commission has met on numerous occasions, both in the body and by telephone conference calls.

The usual review of CHAMPUS claims has been accomplished with only infrequent dissatisfaction with decisions. The Federal fiscal authority in Denver has commended the Indiana program, both for its efficiency and for the apparent satisfaction by the consumer and, in most cases, the provider of care.

Some attempt had been made in the past two years to develop an Insurance Review Committee because of the numerous third party decisions questioned by physicians. This is not completely success-



ful. However, this Commission has been referred numerous insurance as well as Medicaid claims to adjudicate. This has been accomplished following the same format as the CHAMPUS. An average of three to ten claims per month has been reviewed.

The review of insurance claims becomes more complicated because of the multiplicity of physicians and procedures claimed by any one patient. Another problem that has become apparent is the so-called "usual and customary" allowances agreed upon by the insurance company. This varies between different insurance companies and also different physicians in areas of the State. In this area, we have attempted to set some guidelines that will be satisfactory to all. Since the House of Delegates, as yet, has not agreed upon the use of the Relative Value Schedule in the State, we have been somewhat hampered in developing a concept of what is "usual and customary."

It would be the recommendation of this Commission that the Indiana State Medical Society consider forming a commission or committee for the purposes of reviewing third party payments as well as claims questioned by third parties.

In this instance, a source of referral such as a Relative Value Schedule or some such form would be most helpful.

Most of the remaining portions of the meetings were taken up with the review of the Medicaid program, both from the physician's standpoint and also that of the Welfare Department.

There are now 210,000 people eligible for medical care in the state of Indiana. Care is being provided at approximately \$40 per person per month, which is approximately eight per cent higher than in 1968. At that time there were only 68,000 people on welfare.

The total Medicaid budget for 1971 was in excess of \$100 million. The physicians received approximately 10.4% of this in fees.

Some attempt was being made by the Welfare Department to reduce the number of eligibles. However, this has been complicated by the active rights organization and numerous court suits that are in progress.

A minimum income of \$6,500 is being asked for by the rights organizations; however, the Welfare Department is against it, for it would represent a usual income in excess of \$10,000. Anyone even receiving a small service or assistance from Welfare Department becomes eligible for Medicaid, which is a high

cost item to the Welfare Department.

The Welfare Department is satisfied with the administration and fiscal arrangement of Medicaid by Blue Shield and also quite pleased with the cooperation of the state medical society in the care of their indigent. There has been every effort made by the Welfare Department to upgrade physicians' fees within the limits of Federal regulations.

At the present rate of expenditure for 1972, it would seem that the Medicaid budget will be in excess of \$120 million, an increase of 20% over 1971.

The total Federal Welfare budget is in excess of \$23 billion according to HEW in June 1972. This, of course, includes all services.

Information and review regarding the foundation concept for care of the indigent as well as utilization of a CHAPS or pre-admission review has been considered. No definite recommendations can be made at this time for all available information.

The State of Illinois has instituted a review program only in an attempt in the future to possibly use the foundation concept for complete medical care of the indigent. This will have to be watched closely as it is a popular form of providing care. More information will be available on this topic in the future and will be provided to the membership.

I would like to take this opportunity to thank all the members of the Commission for their cooperation and active interest over the past two years. It has been indeed most gratifying for me to be chairman of this Commission and I wish to thank the members of the Executive Staff of ISMA for all their assistance, recommendations and encouragement during my tenure.

MICHAEL J. MASTRANGELO, M.D.  
Chairman

COLA K. NEWSOME, M.D.

FRANCIS H. GOOTEE, M.D.

FRANK BARD, M.D.

RENATE G. JUSTIN, M.D.

TOM S. SHIELDS, M.D.

J. E. HOLMAN, Jr., M.D.

GEORGE E. BRANAM, M.D.

RAMON B. DUBOIS, M.D.

LEE L. TRACHTENBERG, M.D.

GEORGE A. TEABOLDT, Jr., M.D.

PAGE E. SPRAY, M.D.

CHARLES R. ALVEY, M.D.

(At Large)

GLEN V. RYAN, M.D. (At Large)

## Public Health

The Indiana State Medical Association Commission on Public Health had four meetings in the 1971-72 year—November, January, March and May. The Commission, consisting of 16 members, had an average attendance of seven. The faithful loyalty of several members to the needs of the Association is greatly appreciated. Dr. Edgar Cantwell served as secretary; Dr. A. C. Offutt was vice chairman and did much work on: (1) the Commission's report to the National Commission on Marijuana and Drug Abuse, (2) the plan for reorganization of the local health department, and (3) a statement on smallpox immunization. Dr. Warren Niccum provided a good background program on drug abuse and attended a meeting on drug abuse in Arizona for us. Drs. James Hawk, Hubert Goodman and Arnold Brockmole contributed regularly. We were also pleased to have Tim Byers, a member of the Student AMA, with us.

The main work of the Commission was in three fields: (1) drugs, (2) venereal disease, and (3) a plan for regional health departments.

We had a report from Dr. Niccum on his attendance at the AMA's Annual Conference of State Mental Health representatives and heard direct testimony from a drug user. We composed a letter, had it approved by the Board of Trustees, and sent it to Raymond P. Shafer, Chairman of the National Commission on Marijuana and Drug Abuse. This was in reply to a request from the National Commission. The letter said, in essence, that our knowledge of marijuana is fragmentary and will require continued study with respect to: (1) effects of the drug by itself, (2) effects when combined with other drugs, (3) effects on judgment and motor skills, (4) physiological effects, (5) psychological effects, (6) social effects, (7) economic effects, (8) chemical composition, (9) active ingredients, (10) short and long-term effects, and (11) statutory regulations. The letter stressed that there should be an emphasis on the education of our citizens about marijuana.

On the subject of venereal disease, the consensus of the Commission was that the doctors of Indiana needed to have the subject brought before them frequently and from many directions. Dr. Arnold Brockmole agreed to write an article on venereal disease to be published in *The Journal* of the Indiana State Medical Association.

Finally, the main efforts of the Commission were directed to producing a



plan for regionalization of the state's health departments. This action was prompted by the fact that many of the local health departments in the state are inadequate for the important work they are meant to do. The beginning of this effort was a year ago and it came to fruition in a document entitled, "The Regional Health Department—Meeting Modern Demands." This was created and adopted by the Commission and sent to the Board of Trustees of the Indiana State Medical Association with a recommendation for adoption. The Chairman of the Commission, along with Dr. A. C. Offutt, appeared before the trustees of the Indiana State Medical Association at their June meeting to present the proposal. It was accepted for further study and a committee appointed for this purpose. The Commission would hope that this document might be either approved as is, or approved in a form modified, as might be necessary, to be used as a basis for legislation in the near future.

The main provisions of the document are that the state may be divided into fourteen regions, similar to those being used for the hospital and mental health facilities construction program, and each of these regions then would have a health department with the best available qualified personnel and a comprehensive program. Smaller units, such as counties, would continue to have more limited services backed up by the more complete department close by in the region. Economically the state's tax structure cannot support a first-class Board of Health in each county but could support fourteen good regional departments.

Two possible methods of financing are mentioned: (1) funds accrued by uniform regional tax rates would be paid into a special account at the regional level. They would be spent by the regional Board of Health with budgetary review conducted by representatives from the fiscal agencies of each of the participating civil divisions. (2) Tax funds collected as above could be paid into a special dedicated state fund for public health managed by the State Board of Health. The Regional Fiscal Management Group would not be necessary because the state Board of Health would perform this function. Funds from the regions would be pooled and all allocated on the basis of the formula developed by the State Board of Health.

In conclusion, it would appear that we will be getting much improved public health services at possibly no increase

in the cost to the individual taxpayer.

The above brief description is much too general, of course. For the additional information of the House of Delegates, we are concluding this report with an abstract of the more detailed document. Even the original document is really just a starting point in the process of improving public health in Indiana. Copies of the document have been made and, I'm sure, would be available at the Indiana State Medical Association to those interested. The Commission wishes to urge those who are concerned to contribute to the plan by contacting the Commission.

## REGIONAL HEALTH DEPARTMENTS— MEETING MODERN DEMANDS ABSTRACT OF POSITION PAPER

### *Introduction*

Currently in public health, as in other areas, recognition is given to the restrictions placed upon broad programs by limiting them to civil boundaries. Authoritative studies have indicated that Indiana may be divided into fourteen (14) regions which are being used both in the hospital and the mental health facilities construction programs. The proposal in this paper will be that such regionalization be considered with respect to the establishment of jurisdictions for local health departments.

### *The Problem*

The growth of responsibility has reflected the demand of the public for more and sophisticated services. This has resulted in an increase in the duties discharged by local health departments. As a result of the interaction of these two factors, if the local health departments are to meet the demands of the population within their jurisdiction, they must do so by achieving more adequate funding.

### *The Local Health Department*

In order to properly staff and fund local health departments, the cost per capita must be extended over a larger population group. To do this, civic pride in the local health department in each small unit of civil government must be surrendered in favor of a greater good. The jurisdiction of the local health department must, therefore, be extended through the development and operation of official programs on a regional basis.

### *External Influences*

The restricted jurisdiction of existing local health departments apparently does not offer a challenge and recompense which will attract personnel. Activities and services which are properly within the purview of the official local health agency frequently are operated as a function of a voluntary group or as a part of a program in which the health aspect is but a secondary thrust. Regionalization will continue to perpetuate local control of the local official agency in dealing with local problems. The proposed broader jurisdiction will tend to produce a more challenging and varied group of problems and compensation thus helpful in attracting adequate staff.

### *Fiscal Impact*

It is recognized that regionalization will cause certain inherent problems to surface. One of these is because the rural and urban components of the area may generate fears that only the voice of the city will be heard. Careful organization, operation, and education can dispel this fear.

Funds which are accrued by a uniform regional tax rate would be paid into a special account. Such monies would be expended by the board of health with a budgetary review conducted by representatives from the fiscal agencies of each of the participating civil divisions. Certain restrictions would be applied and an annual audit required.

A second method of financing, which is less palatable but is presented since it represents a philosophy to which some subscribe, is presented. Tax funds collected, as noted above, could be paid into a special dedicated state fund for public health which would be managed by the State Board of Health. The region would not need a fiscal management group since this function could be carried on in the fiscal operation of the State Board of Health. If this arrangement were to be adopted, distribution to the regions would then be based on a formula developed by the State Board of Health. In such a case, funds from all regions would be pooled and allocated in accordance with the formula.

### *Regionalization*

Regionalization is not proposed as a method for providing the same service at a lesser cost. The actual proposal involves the more efficient use of personnel, the providing of more of the services which are being required, the transfer of



certain operative functions from the state to local authorities, and a unification of health services in the region. It is recognized that total costs might be increased; but the increase would not be in proportion to the additional services, both in quantity and quality, which could be provided under a regional organization. The per capita cost of providing official health services would be thus spread over a larger population; and, as a result, cost to the individual could conceivably be lessened.

JAMES JOHNSON, M.D.,  
Chairman  
ARNOLD BROCKMOLE, M.D.  
EDGAR CANTWELL, M.D.  
GORDON GUTMAN, M.D.  
WILLIAM B. SIGMUND, M.D.  
HENRY G. NESTER, M.D.  
STANLEY W. BURWELL, M.D.  
HERSCHEL BORNSTEIN, M.D.  
WILLIAM K. NEWCOMB, M.D.  
WARREN NICCUM, M.D.  
JAMES S. ROBERTSON, M.D.  
ANDREW C. OFFUTT, M.D.  
(At Large)  
JAMES HAWK, M.D.  
(At Large)  
HUBERT GOODMAN, M.D.  
(At Large)  
TIMOTHY BYERS (SAMA)

## Voluntary Health Agencies

As in the past, this Commission was organized with representatives from each of the 13 districts with two members at large. The members of the Commission are: Dr. Albert Ritz of Evansville, Dr. Robert Rang of Washington, Dr. T. A. Neathamer of Jeffersonville, Dr. Harry Baxter of Seymour, Dr. Wayne Crockett of Terre Haute, Dr. Frank Deanovic of Richmond, Dr. Lowell Painter of Winchester, Dr. Theodore Person of Covington, Dr. Walfred Nelson of Gary, Dr. Wendell Ayers of Marion, Dr. Richard Willard of Bluffton, Dr. Frank McGue of Michigan City. At-large members are: Dr. A. T. Stone of Indianapolis, Dr. Charles Rushmore of Indianapolis, and a student from the Indiana University School of Medicine, representing the Student American Medical Association, Mr. Richard Schwartz.

The Commission held its organizational meeting on November 21, 1971, and reviewed the constitutional provisions required of this Commission and the operation of the last 10 years. President Dr. Petrich and President-Elect Dr. Gosman met with the Commission at this meeting, and both Mrs. Chernish, president of the Women's Auxiliary and Mrs. Smith, president-elect of the Women's

men's Auxiliary met with the Commission.

The Commission appealed to the Auxiliary in hope that a Commission or a Committee of the Auxiliary parallel to this Commission can be set up and work with the Voluntary Health Agencies of the state. This was implemented at a later meeting.

At this first meeting, the Annual Scientific Program that had been put on in connection with the Indiana Public Health Association was discussed, and it was decided, because of the poor attendance at this activity for the past several years, it would be dropped. Efforts had been made to persuade the directors of Public Health Association to give us more of an audience, but no corrective action was taken.

*The Journal* of Indiana State Medical Association published a list of Voluntary Health Agencies in Indiana and in this list there were some agencies that are unable and unwilling to meet the criteria of this Commission for approval. The Commission asked *The Journal* to consult with this Commission before any such list is published in the future.

It was arranged that at least two doctors of the Commission were assigned in liaison to each of the state organizations with which the Commission works and the agencies were notified of such liaison assignments. It was asked that these members of the Commission be kept informed of the activities of the various agencies and be invited to their business meetings and be invited to sit in on their policy-making Boards.

The next meeting of the Commission was held on January 15, 1972, and Dr. Nelson was elected vice-chairman and Dr. Rang was elected secretary. The Commission reviewed the liaison assignments and made reports on their contacts with various agencies to which they were assigned, and the usual review of agencies took place in which many were approved, but there were some that failed to meet the criteria of the Commission and were not approved. The reasons for failure to meet the criteria are listed in the original minutes of the Commission, but since it is a policy of this Commission not to publish those agencies failing to receive approval, they are not mentioned in this annual report. At this meeting Dr. Petrich met with the Commission and suggested that an extension of our work should be to compile a form to be sent out with the annual report form which gives the evaluation of the work of the agency. The Commission also voted to notify the

Convention Arrangements Committee as to its possible ability to obtain nationally known speakers through the voluntary health agencies for the program of the Indiana State Medical Association.

On the evening of January 15 a dinner was held for the Commission and their wives or guests. This was attended by Dr. and Mrs. Petrich and the Student Representative of the Student American Medical Association, Mr. Schwartz, and his wife.

On Sunday, January 16, the Commission reconvened at the headquarters of the ISMA, and to this meeting all the Voluntary Health Agencies in the state with statewide programs were invited, whether they were approved or not in the past year. Invitations were sent to the president and chief executive officer and five volunteers from each of the agencies. A round-table meeting was held with these agencies. The Commission asked for suggestions and criticism from the agencies, the program was explained, and for the first time the proposed joint program with the Auxiliary was explained to the agencies. They met this plan with real enthusiasm and stated it would be a great help to the agencies to have the ladies participate.

Our Commission asked the voluntary health agencies representatives for any suggestions. Greater participation on the part of the members of the Indiana State Medical Association was requested by many. Some of the agencies thought that greater publicity should be given to the work that this Commission has been doing with the voluntary health agencies. Many suggestions were offered on how it might be possible to reach greater numbers with information. The agencies also reviewed their old programs and discussed their plan for the future. The Commission was complimented on bringing in all the agencies, even though they may not be on the approved list for the previous year.

As a result of the discussion at this meeting, the chairman appointed a special committee from the voluntary health agencies and the commission to work on an evaluation questionnaire.

A general survey of the agencies present revealed approximately 400,000 lay people working as volunteers in voluntary health agencies in the state of Indiana. At noon, a box lunch was served to those present, compliments of the Indiana State Medical Association. The meeting broke up on a very optimistic note for the program of this Commission and the voluntary health agencies together in the future.



The final meeting of this Commission was held at the headquarters of the Indiana State Medical Association on May 7, 1972. At this time the report of the Special Committee to draw up an evaluation sheet to be attached to the annual questionnaire to the agencies was reviewed, slightly revised, and accepted. This evaluation sheet is to be in narrative form in answering four or five additional questions in addition to the factual information required by the criteria in the past. The general form of the criteria questionnaire was also reviewed and corrected to simplify it for the agencies next year.

At this meeting Mrs. Philip Smith, president of the Auxiliary, outlined to the Commission, the efforts of the Auxiliary in response to our request. A committee of the Auxiliary made up of representatives from each of the 13 medical districts has been set up with Mrs. Lois Walker of Yorktown as the chairman. Mrs. Smith is polling the county societies that have Auxiliaries to give us the names of the doctors' wives already working in voluntary health Agencies. Mrs. Smith is also to appoint her liaison committee with Mrs. Walker and submit these names to the Commission for assignment in liaison with the voluntary health agencies in the program of the Commission. She will then assign these ladies to these agencies and, in turn, the agencies will be informed by the Commission of the additional resources of the Auxiliary available to them.

At this meeting of the Commission we were also confronted with the possible expansion of the Commission in the future with the voluntarism in health in general, which seems to be a trend of the National Council of the American Medical Association.

In view of the abandonment of the scientific program, the liaison men of the Commission have been assigned to appear before the annual meetings of the various Voluntary Health Agencies this year to present the program of the Indiana State Medical Association. This program was reviewed and, while it was not perfect, it was felt that it was worth while to consider for another year. The proposition of supplying speakers for the scientific program was also discussed and Dr. Gosman said he intended to follow this up before the meeting of the following year.

The Commission voted to distribute the placards of the names of the approved agencies again this year as in the past, with an additional distribution to

approved hospitals of Indiana and to the county health boards.

The plans for the Commission for the following year were decided upon as follows:

1. Continue the program of approval for each agency as now conducted using the revised questionnaire with the addendum of a program evaluation.
2. To promote and expand the plans for the Auxiliary to appoint a committee of similar number to that of the Commission (one representative from each district) in addition to whomever the Auxiliary president wishes to appoint at large. This list of persons will serve as liaison representative to the voluntary health agencies and, upon the Auxiliary's recommendation, the Commission will then follow up by notifying the voluntary health agencies and by asking that the ladies of the Auxiliary be given responsibility and pertinent information.
3. A report form is to be provided to each liaison man for remarks concerning the agency questionnaire to be returned to the ISMA office, in case he cannot attend the Commission meeting at which the report is reviewed.
4. Plan to continue the Commission's annual January meeting with the officers and executives of the various voluntary health agencies.
5. To publish placards and request the Editorial Board of *The Journal* of the ISMA to publish the contents of the placards at least annually to make reference to it in listing agencies of voluntary health.
6. Continue efforts to work with and get information to medical students.

Along with discussion of possible ways to reach medical students of Indiana University and the Student American Medical Association, Mr. Richard Schwartz has agreed to work out some satisfactory plan in this regard.

We reviewed the 1972 budget which shows the Commission spent \$805.63, and it was moved, seconded and passed that the Commission request the Budget Committee to allocate a budget the same as was spent for 1971-1972 with the understanding that since less was spent than was requested, the Commission would have the privilege of asking the Trustees for any additional small sum, if necessary.

As a result of the work of the Commission this year, the following voluntary

health agencies having statewide programs in Indiana have been given the approval of the Indiana State Medical Association:

The American Cancer Society, Indiana Division.

The Arthritis Foundation, Indiana Chapter.

Indiana Association for Retarded Children.

Indiana Chapter of Hemophilia Foundation.

Indiana Easter Seal Society for Crippled Children & Adults.

Indiana Heart Association, Inc.

Indiana Society for the Prevention of Blindness.

Indiana Tuberculosis & Respiratory Disease Association, Inc.

Kidney Foundation of America.

Mental Health Association in Indiana.

National Multiple Sclerosis Society, Indiana Chapter.

Tri-State Epilepsy Association.

United Cerebral Palsy of Indiana, Inc.

The above list represents the largest list of voluntary health agencies ever approved in the program of the Commission.

The chairman of this Commission again wishes to thank the members of the Commission who have worked long and diligently in the affairs of ISMA in this field. The commission as a whole wishes to thank Mr. Ken Bush for his ever-faithful work with the Commission, and without his help this Commission could not function.

NORMAN R. BOOHER, M.D.,  
Chairman

WENDELL W. AYRES, M.D.

HARRY R. BAXTER, M.D.

WAYNE CROCKETT, M.D.

FRANK DEANOVIC, M.D.

FRANK J. MCGUE, M.D.

T. A. NEATHAMER, M.D.

WALFRED A. NELSON, M.D.

LOWELL W. PAINTER, M.D.

THEODORE PERSON, M.D.

ROBERT H. RANG, M.D.

ALBERT RITZ, M.D.

RICHARD WILLARD, M.D.

CHARLES RUSHMORE, M.D.

(At Large)

ALVIN T. STONE, M.D. (At Large)

MR. RICHARD SCHWARTZ (SAMA)



## Inter-Professional Relations

This commission has been relatively inactive this year. Unfortunately, too little has been done in the past and present to cultivate a good working relationship with the other allied medical professions.

My recommendation, as chairman, for the coming year is that the officers and trustees of the Indiana State Medical Association give high priority to making this commission one of our strongest commissions since the coming years will require a united front of all the allied medical professions to give leadership in our delivery of medical care.

FRED W. DIERDORF, M.D.,  
Chairman (At Large)

JACK L. SHANKLIN, M.D.

IGNACIO B. CASTRO, M.D.

GERALD BOWEN, M.D.

RICHARD L. VEACH, M.D.

MARK E. SMITH, M.D.

WILLIS W. STOGSDILL, M.D.

AMBROSE PRICE, M.D.

PAUL E. LUDWIG, M.D.

MITCHELL E. GOLDENBURG, M.D.

H. H. DUNHAM, M.D.

MARVIN PRIDDY, M.D.

RICHARD W. HOLDEMAN, M.D.

WARREN COGGESHALL, M.D.

(At Large)

GARRE BLAIR (SAMA)

## Medical Economics and Insurance

The Commission on Medical Economics and Insurance met five times during the year. There was one joint meeting with the Commission on Governmental Services and one joint meeting with the Future Planning Committee. During one meeting the Commission on Medical Economics and Insurance met with representatives of Blue Shield and with representatives of Blue Cross to discuss current problems.

The Commission on Medical Economics and Insurance had continued reviews of the ISMA Group Insurance Programs:

(a) *Group Disability Program.* Enrollment of new members continues at a steady rate. The program remains sound, and the loss experience has been satisfactory. It is expected that 10 percent increase in benefits added last year will be continued for another year.

(b) *Group Life Insurance Program.* There have been no problems to

date. In addition, the Group Permanent Life Plan added last year is making satisfactory progress.

In response to requests and following the recommendations of the survey made two years ago, the Commission has been endeavoring to arrange other group programs. Under study as this report is being prepared are:

(a) *Excess Major Medical Program.* This supplemental coverage will be available in \$15,000 and \$25,000 deductibles up to \$100,000 for members and dependents. The premiums are low and this program will be recommended to the board of Trustees for approval this fall.

(b) *Overhead Expense Insurance Plan.* This proposed program has been reviewed; and, if minor modifications can be arranged, the Commission plans to recommend this program to the Board of Trustees for approval this fall.

We regret that no satisfactory *Group Automobile Insurance Program* has been offered, but such programs are under review. It should also be noted that no carrier has offered to write *Group Liability Insurance* on a satisfactory basis. Experience in some other states is proving less than satisfactory. In the past year the Commission on Medical Economics and Insurance and the ISMA staff have noted a marked decrease in the number of ISMA members approaching them because of problems in this area. Hopefully this is a good omen.

A large portion of the activities of the Commission, both in meetings and in individual contacts, dealt with a multitude of problems relating to third-party payment. Perhaps this is a normal evolution of the meetings between ISMA members and the Ad Hoc Committee on Blue Shield. It is obvious to the Commission that there is great concern, disenchantment and dissatisfaction expressed by many ISMA members about Blue Shield, Blue Cross, as well as other carriers. Many of the problems relate to misunderstandings and poor communications, both between carrier and physician, between carrier and patient, as well as to the arbitrary actions by some carriers. Pertinent to this matter is a summary of actions taken by the House of Delegates of the AMA in June 1972, which said in part:

### *Fee Determinations*

Delegates approved a strong resolution aimed at any independent determination

of customary physicians' fees:

"Resolved, that where benefits include physicians' fees, management, labor and third party carriers shall consult with duly constituted representatives of organized medicine before determining 'usual, customary and reasonable fees,' " the measure said.

"The medical profession will not condone or tolerate action on the part of any third party that would encourage or promulgate litigation in the settlement of any such dispute." This referred to a practice of telling a policyholder that—except where there was prior agreement between patient and physician as to the fee—the insurance company would pay the patient's legal costs if the physician sued to collect his full fee.

The resolution also reminds physicians "that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered."

The Commission on Medical Economics and Insurance recommends to the House of Delegates of the Indiana State Medical Association:

(1) The above statement be adopted by the ISMA.

In addition, the Commission on Medical Economics and Insurance recommends to the House of Delegates of the Indiana State Medical Association adoption of the following:

(1) That each county medical society establish a professional Review and/or Fee Review Committee.

(2) In the event a county medical society does not wish to establish such a committee, the district society may do so.

(3) In the event that Nos. 1 and 2 cannot be accomplished, the House of Delegates of the ISMA empower the president of ISMA to appoint such a committee. Such a committee be empowered to arbitrate those cases in which local solution cannot be achieved.

(4) That if a carrier elects to use such committee, they be bound by the findings of the committee.

(5) Such a program be self-sustaining by charging a fee to the carrier for such a review.

In addition, the Commission on Medical Economics and Insurance recommends the approval of a form for the use of ISMA members in estimating charges for a procedure in the cases where insurance contracts require previous agreement of fees in order for the physician to collect his usual charge. Thus there could be no misunderstanding between the physician, patient, and







Further we recommend that under no circumstances shall such a corporation be permitted to provide direct medical care or to participate in risk-sharing.

COMMISSION ON MEDICAL  
ECONOMICS AND INSURANCE  
Lowell H. Steen, Chairman  
COMMITTEE ON  
FUTURE PLANNING  
Kenneth O. Neumann, Chairman

## Medical Education and Licensure

The Commission met on December 19, 1971, March 12, June 11, and September 10, 1972. In addition to the regular members in attendance, several guests and consultants also attended and participated in the work of the Commission. These included the ISMA president, Peter R. Petrich, M.D., and the president-elect, James Gosman, M.D. Also attending were Steven D. Berkshire, program coordinator for postgraduate education at the Indiana University School of Medicine, and SAMA representatives, Mr. Robert Green, Mr. Robert Daley, and Miss Jane Henney, the Indiana coordinator for SAMA-MECO Project. Dr. George Lukemeyer attended one meeting, representing the dean's office at the Indiana University School of Medicine. Dr. Earl Braunlin, ophthalmologist, and Mr. Bill Wehrenberg also attended one meeting as guests.

I. Work referred to the Commission by Action of the 1971 ISMA House of Delegates included Resolutions 71-14 and 71-15, as well as the proposed Uniform Medical Practice Act. Action on the referred business is as follows.

A. Resolution 71-14, Encouraging Participation in Continuing Medical Education to Fulfill Requirements of the American Medical Association's Physician Recognition Award.

1. The Commission recommends adoption of the following to encourage ISMA members to participate in continuing medical education:

a. Establish a new category of ISMA membership to be called "Distinguished Member," based on Fulfilling the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum. The ISMA membership card to be issued to the Distinguished

Member should be distinctive, such as a gold card and properly identified as "Distinguished Member."

b. Provide an ISMA Award Seal to be attached to the AMA-PRA certificate and presented at the annual meeting to members fulfilling the minimum requirements.

c. Use the AMA-PRA report form with their categories of continuing medical education with the addition of a category accepting a specialty board recertification or proof of fulfilling a specialty group's continuing medical education requirements as evidence of meeting the minimum requirements for the Indiana Award.

B. Resolution 71-15, Statewide continuing Medical Education Accreditation System.

1. The Commission developed a Subcommittee on Continuing Medical Education as directed by this resolution. The work of this subcommittee included work on Resolution 71-14 as well as Resolution 71-15, since they are interrelated. The report of the subcommittee was approved by the Commission so that their recommendations are being made by the Commission. Members of the subcommittee and their organizations are listed as follows:

Robert Nagan, M.D. (American College of Surgeons)

Eugene M. Gillum, M.D. (Indiana Academy of Family Practice)

Victor H. Muller (Indiana Association of Pathologists)

Donald F. MacLeod, M.D. (Indiana Thoracic Society)

Iver Small, M.D. (Indiana Psychiatric Society)

Lewis F. Morrison (Indiana Academy of Ophthalmology and Otolaryngology)

Raymond O. Pierce, Jr. (Indiana Orthopaedic Society)

Richard Hamburger (Indiana Society of Internal Medicine)

William D. Dannacher (International College of Surgeons)

Jack H. Hall (AIDME)

Steven D. Berkshire (I.U. School of Medicine)

Steven C. Beering, M.D. (I.U. School of Medicine and Commission Member)

Jene R. Bennett, M.D. (Commission Member)

Ross L. Egger, M.D. (Commission Member)

Shokri Radpour, M.D. (Commission Member)

Norman J. Wilson, M.D. (Commission Member)

Franklin A. Bryan, M.D., (Commission Member)

2. The Commission recommends adoption of the following regarding an accreditation system:

a. The Commission will accredit programs, institutions, or organizations rather than individual courses or lectures. These will be in-state, non-university programs such as state medical, county medical society, local hospital, or voluntary health organizations. Accreditation will be requested by the agency developing and presenting the program.

b. When a program, institution, or organization has been accredited, it will be granted a certificate of accreditation for a specified period of time.

c. Accreditation will be based on fulfilling the AMA requirements as presented in the AMA "Essentials for Continuing Medical Education."

d. The system of accreditation will include the completion of a pre-survey questionnaire by the applicant program, institution, or organization, followed by a site visit inspection. The site visit team reports to the Commission and makes their recommendation. Temporary accreditation may be granted pending the site visit inspection if the pre-survey questionnaire appears to be satisfactory.

e. The subcommittee of the Commission should be maintained to aid in the implementation and maintenance of the accreditation system.

f. All documents pertaining to the administration of the program have been developed and have been approved by the Commission and will be utilized in the conduct of the program when the accreditation plan is approved by the ISMA House of Delegates.



### C. Proposed Uniform Medical Practice Act.

1. The Commission presented the proposed Uniform Medical Practice Act at four hearings over the state, inviting all ISMA members to participate. Members of the Indiana Association of Osteopathic Physicians and Surgeons and their attorneys were invited also and participated. Dr. Merritt Alcorn and the Commission chairman attended all hearings and presented the material while other members of the Commission attended in their districts and helped in the necessary arrangements. All hearings were recorded and transcribed and all suggestions are being considered in rewriting the proposed Act for Indiana for presentation to the ISMA for their action.

2. The hearings were held in Fort Wayne on April 4 and 5, in Evansville on April 11, in Gary on May 3 and in Indianapolis on May 16.

### II. Some other subjects and problems considered by the Commission were (A) Indiana University School of Medicine, (B) Student-Faculty-ISMA Retreat, (C) SAMA, (D) Family Practice Preceptorship.

#### A. Indiana University School of Medicine.

1. As in past years, a very close liaison between the medical school and the Commission existed. At each meeting one or more representatives of the dean's office were in attendance to report on the status of the school and to answer questions. They have worked on the subcommittee for continuing medical education and accreditation and have contributed much.

#### B. Student-Faculty-ISMA Retreat.

1. The Commission worked closely with the medical school faculty and students in planning the Student-Faculty-ISMA Retreat. The ISMA representative on the planning committee was Commission member, Dr. Ross Egger. The results of the Retreat and recommendations were tabulated and will be presented to the Commission and the Indiana State Medical Association.

#### C. SAMA.

1. Representatives of SAMA attended the meetings and presented their viewpoints on several subjects. In

addition to the Retreat they presented the SAMA-MECO Project for information and the subject of the student-evaluation system of the medical school. In addition, the student representatives were most helpful in their discussions on many subjects.

#### D. Family Practice Preceptorship.

1. This program was carried out this year in cooperation with the Family Practice program of the Indiana University School of Medicine. Dr. Ross Egger represented the Commission on the Preceptor Committee. Under the new structure the program is much better organized than in the past.

Many other subjects were studied and acted upon by the Commission, including the physician assistant and legislative matters presented at the last legislature.

The Chairman thanks all the members of the Commission for their participation in the work during the year. The Chairman also thanks all of the consultants and guests who have contributed much to the work of the Commission. The Subcommittee on Accreditation deserves the gratitude of the Commission for the many hours dealing with continuing medical education and accreditation.

The Commission thanks the ISMA staff, specifically Mr. Ken Bush and Mrs. Mary Alice Cary, for their outstanding support and extra effort in helping with the large volume of work this year which could not have been possible without their assistance.

FRANKLIN A. BRYAN, M.D.,  
Chairman

ROSS L. EGGER, M.D.,  
Vice Chairman

NORMAN WILSON, M.D., Secretary

GILBERT HIMEBAUGH, M.D.

BETTY DUKES, M.D.

DANIEL CANNON, M.D.

GEORGE G. MORRISON, JR., M.D.

STANLEY FRODERMAN, M.D.

DAVE ELLIS, M.D.

DONALD M. SCHLEGEL, M.D.

SAMUEL C. MILLS, M.D.

SHOKRI RADPOUR, M.D.

JENE R. BENNETT, M.D.

MERRITT O. ALCORN, M.D.

PETER J. PILECKI, M.D.

GLENN W. IRWIN, JR., M.D.

STEVEN C. BEERING, M.D.

ROBERT GREEN (SAMA)

### Special Activities

During the 1971-72 year the Commission on Special Activities made significant headway in two important areas of topical interest and concern: drug addiction and rural health. In our deliberations we much appreciated the presence and opinions of Dr. Peter Petrich, president, and Dr. James Gosman, president-elect of ISMA, and the special expertise brought to our meetings by a number of invited eminent guests who freely gave of their time. They included, among others, Dr. William Murray, State Commissioner of Mental Health; Dr. Frank Osberg, Director of Drug Abuse Division, State Department of Mental Health; Dr. Richard D. Hawkins, President of the Bedford Medical Center; Dr. A. Alan Fischer, Director, Family Practice Program, Indiana University School of Medicine; Drs. Eli Goodman and Dwight Schuster, members of our Board of Trustees; and Mr. Michael Quinn, Executive Director of the Community Addiction Services Agency, Inc. (CASA).

The Commission referred to the Board of Trustees the following memorandum from Dr. Alan Fischer with a recommendation that it be supported.

"The Board of Trustees of Indiana University approved the development of a Family Practice Program at IUMC and named Dr. A. Alan Fischer director in February 1971. He was charged to develop the Family Practice curriculum, secure faculty, and develop the entire structure for academic teaching of Family Medicine at the undergraduate, graduate, and postgraduate years. When accomplished, a full Department of Family Medicine was to be formed and Doctor Fischer was to be the first department chairman.

"The above has been carried out to the point that only funds are now blocking the full implementation of the Family Practice Program at Indiana University, due to the last legislature's severe cut in university funding. There are at present no funds available to begin the Family Practice Program. It is hoped that some money will soon be available through the Health Manpower Assistance Act and the Family Practice Act, but if such funds are not available by January 1, 1973, it is hoped that emergency legislation will be introduced and passed by the State Legislature. A Bill for this purpose is now being formed and modeled after other states which have been forced to go this route for financing their Family Practice De-



partments. Although there are university reasons for firmly opposing special categorical funding legislation for medical schools, I.U. does not oppose this as a needed measure for the Family Practice Department. The help of this Commission on Special Activities in bringing this problem to the attention of the ISMA would be greatly appreciated. The support of the ISMA when this legislation comes before the legislature would be of tremendous help. I am, therefore, suggesting that the ISMA issue a statement strongly supporting the Department of Family Medicine at Indiana University as suggested above."

In the area of drug abuse, the Commission was actively engaged in the planning of a two-day Drug Training Institute, to be chaired by Dr. Hanus Grosz, at Stouffer's Inn, Indianapolis. The program, scheduled for July 12 and 13, 1972, was co-sponsored by ISMA, Indiana Department of Mental Health, the Indiana Academy of Family Practice and Pfizer Pharmaceuticals, which has very generously taken on the financial burdens of the Institute.

The recently formed subcommittee on Drug Addiction and Alcoholism, chaired by Dr. Dwight Schuster, reviewed the role of ISMA in drug education and came up with a number of recommendations: one, that ISMA distribute to its membership an existing manual on the "Treatment of Acute Drug Intoxication"; two, that ISMA and the county medical societies be presented with a directory of drug clinics and drug programs in Indiana to be used as a source of referral information; and three, that ISMA assist the county medical societies with speakers and programs on drug abuse.

Finally, the Commission appointed a subcommittee on rural health. Members of the subcommittee were Richard D. Hawkins, M.D., Bedford, chairman; Hanus Grosz, M.D., James H. Gosman, M.D., George M. Ellis M.D., Eli Goodman, M.D., Donald Hunsberger, M.D., and John C. Linson, M.D.

The Committee has actively studied the problems of physician recruitment and health care delivery in rural and non-metropolitan areas of Indiana during 1972. These studies have consisted of probing meetings with representatives of the Indiana State Board of Health, the Comprehensive Health Planning Agency, the Indiana State Board of Health, the Indiana Regional Medical Program and the I.U.-P.U. School of Medicine. The medical school representatives con-

sisted of the directors of the Family Practice Department and the Department of Community Health Sciences as well as medical students. In addition, the Family Medicine Department of Methodist Hospital of Indianapolis and the layman consumer of health care were represented.

The committee has summarized its findings as follows:

1. An insufficient number of primary care physicians are entering practice as solo practitioners in the rural and non-metropolitan areas of Indiana to meet the consumers' need.
2. Solo practice is and will remain an important entity in the delivery of health care in Indiana. However, the committee finds that interest in this type of practice is on the decrease in recent graduates both in Indiana and throughout the country. This fact is more specific as it pertains to practice in non-metropolitan areas.
3. There is a great need at the medical school and graduate levels of medical education for the enthusiastic encouragement of the primary care specialties, more specifically, the encouragement of physicians to enter the fields of Family Practice, General Pediatrics and General Internal Medicine. It is suggested that this could be better accomplished by the presence of instructors in these fields with contagious attitudes of enthusiasm and the elimination of the uncompimentary vocal opinions concerning "L.M.D.'s" emanating from many resident staffs.
4. In areas of non-metropolitan Indiana where group medical practices exist there is a good supply of physicians and there is undeniable evidence that physician recruitment is successful. It is also suggested that there is an improved supply of solo practitioners in some of these areas.
5. There is evidence that new and modern hospital facilities alone do not attract physicians. These facilities are an absolute requirement but are not successful unless accompanied by an organized recruitment effort. The facts reveal that adequate and modern facilities coupled with group medical practice is the successful formula at the present time.

The committee recommended to the Commission on Special Activities of the Indiana State Medical Association that

the following resolution be submitted to the Board of Trustees of the Indiana State Medical Association for possible adoption at the 1972 meeting of the House of Delegates. The Board adopted the resolution.

BE IT RESOLVED that the Indiana State Medical Association endorses the formation of Group Medical Practices in the State of Indiana as means to improve the supply of physicians and to improve the delivery of health care in certain problem non-metropolitan and rural areas. The term Group Medical Practice, as herein used, is defined by the American Medical Association as follows:

"Group Medical Practice is the application of medical service by three or more physicians formally organized to provide medical care, consultation, diagnosis, or treatment, through the joint use of equipment and personnel, and with income from medical practice distributed in accordance with methods previously determined by members of the group"

FURTHER, the Indiana State Medical Association shall support the implementation of the formation of such Group Medical Practices in problem areas of the state through the authorization of the appropriate Commission and committees by the Board of Trustees to assist involved communities, county medical societies and related planning and development groups.

FURTHER, the Indiana State Medical Association encourages that such Group Medical Practices be formed from nuclei of physicians that have established practices in the involved community and who exhibit cooperative interest in the formation of group practice in an effort to attract needed physicians and to improve available health services to the consumer in the area.

FURTHER, the Indiana State Medical Association continues to endorse the Solo Practice of Medicine, inasmuch as many physicians prefer this method of practice and cannot suitably adapt to the requirements that are necessary for the successful operation of Group Medical Practice.

FURTHER, the Indiana State Medical Association finds no evidence that the existence of Group Medical Practices in Indiana or in other states compromises the position of the Solo Practitioner and that the Solo Practitioner will continue to be an important part of the Health Care Delivery System in America.

HANUS J. GROSZ, M.D. Chairman  
RICHARD B. HOVDA, M.D.



WILLIAM H. GARNER, Jr., M.D.  
 JOHN C. LINSON, M.D.  
 FRED E. HAGGERTY, M.D.  
 DONALD HUNSBERGER, M.D.  
 THOMAS J. STOLZ, M.D.  
 ADOLPH WALKER, M.D.  
 NORMAN BEAVER, M.D.  
 EVERETT DONNELLY, M.D.  
 PETER E. GUTIERREZ, M.D.  
 (At Large)  
 ROBERT P. ACHER, M.D. (At Large)

## COMMISSION STATEMENT ON HEALTH CARE IN NURSING HOMES

It is high time, in the opinion of the Indiana State Medical Association's Commission on Aging, that citizens of this state are apprised of the erosion in the health care which is allowed Medicare and Medicaid patients in nursing homes and of the frustrations of physicians thwarted in their efforts to provide quality service to them.

Experience with the Medicare and Medicaid programs has revealed glaring deficiencies; some built into the concepts of the programs and others complicated by restrictions of benefits, but all at the expense of the patient and the physician trying to take care of him.

Thus it is imperative, the Commission believes, that the medical profession and operators of extended care facilities offer recommendations; hopefully, to bring about changes in a situation which is becoming unbearable or, if unavailing, to have the conclusions of these experts a matter of written record.

The privilege of attaining old age is not given to everyone, but the number of persons reaching it is increasing. It is unconscionable, then, that provision of their health care is sinking in a bog of federal regulations established to make that care fit the money available and not to insure its quality. It is equally unconscionable to expect dedicated physicians to labor under regimentation which limits so severely their ability to provide adequate care that many elect not to participate at all.

The political promise of health care for all the aged, regardless of need, may have been well-intended. Certainly it was politically expedient. Performance, however, has proved to be miserable. Congressional disregard of repeated warnings that the cost of such programs was woefully underestimated, especially when Medicare was designed to embrace everyone over 65 instead of just the needy elderly, has come home to roost.

"Cost containment" now has become paramount, regardless of the fact that patient benefits are increasingly restricted, that care in custodial facilities is not covered, and that "containment" infers that physicians have found a windfall in care of the elderly in nursing homes, thus tarring all for the transgressions of extremely few.

Consider: When a convalescent patient leaves a hospital, application must be made to an extended care facility. This involves paperwork, telephone calls, consultation with relatives and orders,

among other things, for the doctor. If the patient is accepted, the physician must visit him within 48 hours, and must see him again in two weeks. The physician receives a fee for one visit only, and that is reduced if he sees other patients in the facility at the time, and the patient is subjected to a transition from frequent medical supervision to a monthly visitation unless the doctor can substantiate, by additional paperwork, that additional visits are medically necessary.

It is a nurse, or clerk, however, who rules on the substantiation and in precious few cases is it approved. Thus, a decision made by Medicare or Medicaid intermediary (Blue Shield, in Indiana) certainly overrides a physician's medical knowledge and judgment, leaves the patient without adequate care, and repels the doctor. Few doctors are inclined to accept such treatment and to accept reduced fees in addition. And, as a final blow to the patient and his family, the length of stay in hospitals or extended care facilities for which the federal programs will pay is severely limited. The disenchantment becomes complete.

With the foregoing, albeit cursory, in mind, the Commission makes the following recommendations to correct an intolerable state of affairs:

1. Remove all but the needy elderly from eligibility for Medicare and apply the moneys thus husbanded to proper medical, extended care and custodial care for the indigent.

2. Publicize widely, thereafter, to doctors and patients and their families what Medicare and Medicaid will, and will not cover.

3. Eliminate duplication of inspections and audits of nursing homes and reduce the paperwork now required to a minimum.

4. Provide for blanket allocations of funds to extended care facilities to cover medical fees, nursing services, drugs, food and shelter, thus ending dictation of the federal government and its regulations, and making local operations and services a matter for local decision.

5. Provide for peer review by local medical societies to insure against abuses and to remove medical decisions from lay control.

6. Finally, establish a central office, manned by knowledgeable employees of the Social Security Administration, Blue Shield and the Department of Public Welfare, where a patient, his relatives, or a physician can obtain correct informa-

## Aging

The Commission met on November 21, 1971, March 12, May 21, and July 9, 1972.

The Commission agreed that Joel W. Salon, M.D., would represent the Indiana State Medical Association at the White House Conference on Aging in Washington, D.C., and that he express the Indiana State Medical Association statement of policy on aging as stated in the 1971 report of the Commission.

The Commission engaged in lengthy discussions on the medical care of the aged in the office, home and nursing home and on the dignity of the aged in death and dying.

A motion carried that the Commission Report on Nursing Homes, submitted to the Executive Committee and to the Board of Trustees, and the Commission-adopted Indiana State Medical Association Policy Statement on Death be made a part of the 1972 annual report of the Commission.

## INDIANA STATE MEDICAL ASSOCIATION STATEMENT OF POLICY ON DEATH

1. Aging is a natural process of life.
2. Death is a natural result of many disease and/or degenerative processes.
3. The science of medicine is able, at best, to postpone death.
4. Inability to live satisfactorily is by many considered to be less desirable than death.
5. The responsibility of the physician is to outline from available information the quality of life that can be expected.
6. The individual whose life is at stake should have an opportunity to take part in plans regarding his chances of recovery to lead a satisfactory life.
7. It is the moral responsibility of the physician to prolong life except when there is no chance of the sufficient recovery of the patient to lead a satisfactory life unless, in such case, the patient or a responsible relative requests that life and breath be maintained by extraordinary means.



tion at one source and not be referred to one office after another.

WALLACE R. VANDENBOSCH, M.D.,  
Chairman  
JOHN D. WILSON, M.D.  
RAYMOND DUNCAN, M.D.  
A. W. CAVINS, M.D.  
ALBERT M. DONATO, M.D.  
THEODORE R. HAYES, M.D.  
DANIEL RAMKER, M.D.  
JAMES McLAUGHLIN, M.D.  
JOEL W. SALON, M.D.  
DANIEL G. BERNOSKE, M.D.  
(At Large)  
MR. MICHAEL BUBB (SAMA)

## Emergency Medical Service

The Commission met several times during the year and considered a number of items in the area of emergency medical services.

The Commission discussed the result of the survey which had been made of all Indiana hospitals concerning the equipment being utilized in their emergency rooms and sent the summary report to the following groups: Hospitals and Institutional Services, Division of the Indiana State Board of Health; secretaries of all county medical societies; Commission on Emergency Medical Services members; members of the Emergency Medical Services State Advisory Committee; Chiefs of Hospital Staffs; health officers in the state; secretaries of district medical societies; hospital administrators; secretary of the Indiana State Board of Health; the Indiana Department of Transportation; and the local Department of Health Education and Welfare.

On Sunday, January 23, the Commission met with representatives of a number of organizations to discuss the role of the helicopter in Indiana emergency disaster medical services. The following representatives were invited to this meeting: The Indiana Association of Fire Chiefs, the Indiana Association of Police Chiefs, Indiana National Guard, State Police, State Highway Commission, Grissom Air Force Base, Fort Benjamin Harrison, Civil Air Patrol, American Red Cross, State Sheriff's Association, Office of Traffic Safety, Indiana State Board of Health, and a

number of chairmen from the Governor's Advisory Committee on Emergency Medical Services. Also invited were Indiana General Assembly senators and representatives who were serving on various committees in the Assembly structure concerned with public health matters.

The meeting which followed was an extraordinary one since exchange of information was technically revealing on the capabilities of helicopters in various classifications.

Following the meeting and after a very serious discussion of the role, the Commission adopted the following statement as a policy:

"It does not appear feasible at this time to consider the development of a medical helicopter service for the State either on a public or private basis. Medical helicopter support will have to be obtained from a separate helicopter support system such as that proposed by the Indiana State Police or that provided by the military. Heliports and helipads should be developed on a gradual basis starting with the larger hospitals and as the air-ambulance system develops."

In summary of the year's activity of the Commission, the Commission wishes to recommend the following points as vital considerations by the Indiana State Medical Association in the area of emergency medical services:

- (1) There should be a more vigorous approach to the improvement of the services available in hospital emergency departments.
- (2) There must be an upgrading of ambulance service because this service is the real backbone of transportation of the patient with an emergency problem. ISMA should lend a much more active support to the ambulance bills which will be coming before the legislature by reviewing this legislation, carefully, and offering alternative proposals, such as discussed by the Commission during the year, should the need seem to be appropriate.
- (3) An active program should be instituted in emphasizing the im-

portance of construction and maintenance of heliports and pads. A program is being coordinated with the superintendent of State Police to establish model plans for development of helipads and necessary maintenance criteria.

- (4) The Commission is convinced that helicopters will play an ever-increasing role in transporting the emergency medical patient from the scene of emergency to the hospital and also from the hospital to other hospitals with more specialized services.

In view of the fact that the Indiana State Medical Association has supported, in cooperation with other organizations, an ambulance bill which has failed in the last two legislatures, the Commission considered an alternative proposal in this particular area of legislation, which is included in the minutes of the meetings of the Commission.

The Commission feels that the bill which has failed is perhaps all-encompassing and that more gain could be accomplished in the State Legislature by submitting a bill which would request legislation on some or part of the total need.

The Commission suggests that the Commission on Legislation of the Indiana State Medical Association give consideration to this suggested bill, as outlined by the Commission, should it appear that, once again, this much needed legislation appears headed for defeat in 1973.

CLEON SCHAUWECKER, M.D.  
Chairman (At Large)  
FORREST J. BABB, M.D.  
NEAL E. BAXTER, M.D.  
ROBERT M. BROWN, M.D.  
JOHN S. FARQUHAR, JR., M.D.  
JAMES D. FINFROCK, M.D.  
DONN R. GOSSOM, M.D.  
WILLIAM F. KERRIGAN, M.D.  
JAMES W. KRESS, M.D.  
RAYMOND W. NICHOLSON, M.D.  
WILLIAM F. NOWLING, M.D.  
JOHN G. SUELZER, M.D.  
(At Large)  
HOWARD S. WILLIAMS, JR., M.D.  
MR. BRUCE P. WILLIAMS (SAMA)



# Resolutions

## Amendments to the Constitution to be Voted on at Indianapolis Session, 1972

At the 1971 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, in which the Reference Committee recommended for adoption the following amendment to the Constitution:

Therefore, Be It resolved, to amend Article V of the Constitution by adding an additional paragraph after the first paragraph to read as follows: "All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation."

### Resolution No. 72-1

**Introduced by:**

MARION COUNTY  
MEDICAL SOCIETY

**Subject:**

INDIANA MEDICAL HISTORICAL FOUNDATION

**Referred to:**

REFERENCE  
COMMITTEE No.—

WHEREAS, at the turn of the century, Dr. Frank Wynn, then chairman of the Pathology Committee of the Indiana State Medical Association, suggested that the Association assume responsibility for the medical heritage and artifacts of the State of Indiana, and

WHEREAS, the Indiana Medical Historical Foundation now has been organized and incorporated as a not-for-profit, tax-exempt entity to achieve that end, and

WHEREAS, the Foundation already has functioned to preserve the old pathology building on the grounds of Central State Hospital, in Indianapolis, and

WHEREAS, the building now is recognized and listed on the National Register of Historical Places by the United States

Department of the Interior; and

WHEREAS, the Foundation already has collected numerous artifacts, paintings and photographs relating to the history of medicine in Indiana; and

WHEREAS, the Commission on Medical Education and Licensure of the ISMA has contributed \$10,000 from the Association's Medical Education Fund to match \$10,000 contributed by the Lilly Foundation to support the Foundation;

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association now assume the responsibility for the continued operation of the Foundation and its purposes and for the preservation and maintenance of the pathology building, and that the Association establish an Historical Commission to guide the Foundation, seek funds to support it and urge its membership to contribute to it.

### Resolution No. 72-2

**Introduced by:**

VANDERBURGH  
COUNTY MEDICAL  
SOCIETY

**Subject:**

LEGISLATION TO  
DEFINE THE WORD  
"PHYSICIAN"

**Referred to:**

REFERENCE  
COMMITTEE NO.

WHEREAS, Indiana courts have construed the word "physician" to include a person engaged in the practice of chiropractic; and

WHEREAS, the term "physician" is ordinarily understood by laymen to signify persons who are graduates of schools of medicine or schools of osteopathy; and

WHEREAS, the application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

WHEREAS, this is confusing to the public, and therefore not conducive to the maintenance of a consistent standard of health care;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine or Doctor of Osteopathy.

### Resolution No. 72-3

**Introduced by:**

VANDERBURGH  
COUNTY MEDICAL  
SOCIETY

**Subject:**

SUBSTITUTING TB  
PATCH TESTS IN  
LIEU OF CHEST  
X-RAYS

**Referred to:**

REFERENCE  
COMMITTEE NO.

WHEREAS, recent state legislation has been changed from the requirement that school teachers and other school personnel receive an annual chest x-ray to the requirement that they receive an annual Mantoux test for tuberculosis; and

WHEREAS, existing state law requires beauticians and barbers to receive an annual physical examination, which may include a chest x-ray at the discretion of the examining physician; and

WHEREAS, local ordinances in many areas require various other types of individuals—such as food handlers, hospital personnel, etc., to receive annual chest x-rays; and

WHEREAS, the present feeling of many in the medical community is that skin testing affords a better method for detecting individuals to be considered for medical therapy; and

WHEREAS, the opinion prevails in many areas that the chest x-ray as far as the tuberculous disease process be reserved for those individuals known to be positive reactors to the Mantoux skin test;

NOW, THEREFORE, BE IT RESOLVED the Indiana State Medical Association recommend to individual physicians and to appropriate legislative units that all those persons who in the past have been required to have an annual chest x-ray shall now receive appropriate skin testing with chest x-ray considered for positive reactors to the skin test.



## Reference Committees

### CREDENTIALS COMMITTEE

T. Neal Petry, Delphi, *Chairman*  
Thomas A. Elliott, Elkhart  
Robert M. Brown, Marion  
Arvine G. Popplewell, Indianapolis

### TELLERS

Lowell W. Painter, Winchester,  
*Chairman*  
Robert A. Hedgcock, Frankfort  
Bernard B. Rosenblatt, Evansville

### REFERENCE COMMITTEE NO. 1

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T. Neal Petry, Delphi (Carroll)  
Thomas A. Elliott, Elkhart (Elkhart)  
Robert M. Brown, Marion (Grant)  
Lowell W. Painter, Winchester (Randolph)  
Robert A. Hedgcock, Frankfort (Clinton)  
Bernard B. Rosenblatt, Evansville (Vanderburgh)

### REFERENCE COMMITTEE NO. 2

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Howard C. Jackson, Madison (Jefferson-Switzerland)  
Edwin S. McClain, Indianapolis (Marion)  
Robert D. Williams, Anderson (Madison)  
Max N. Hoffman, Covington (Fountain-Warren)  
Joseph J. Sala, Gary (Lake)

George M. Haley, South Bend (St. Joseph)

### REFERENCE COMMITTEE NO. 3

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Marvin L. McClain, Scottsburg (Scott)  
Harry R. Baxter, Seymour (Jackson-Jennings)  
Joseph W. Young, Greenwood (Johnson)  
George M. Underwood, Lafayette (Tippecanoe)  
Walfred A. Nelson, Gary (Lake)  
Donald G. Mason, Angola (Steuben)

### REFERENCE COMMITTEE NO. 4

Betty Dukes, Dugger (Sullivan), *Chairman*  
David H. Jones, Charlestown (Clark)  
Fred W. Dierdorf, Terre Haute (Vigo)  
Eugene T. Karnafel, Logansport (Cass)  
Thomas Hamilton, Columbia City (Whitley)  
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### REFERENCE COMMITTEE NO. 5

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Louis H. Blessinger, Corydon (Harrison-Crawford)  
Dillon Geiger, Bloomington (Owen-Monroe)  
C. David Ryan, Columbus (Bartholomew-Brown)  
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### REFERENCE COMMITTEE NO. 6

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Fred C. Poehler, LaFontaine (Wabash)  
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### REFERENCE COMMITTEE NO. 7

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Glen McClure, Sullivan (Sullivan)  
Fred E. Haggerty, Greencastle (Putnam)  
I. E. Michael, Indianapolis (Marion)  
Martin O'Neill, Valparaiso (Porter)  
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Earl R. Leinbach, Hamlet (Starke) At Large  
Richard D. Hawkins, Bedford (Lawrence) At Large



# Scientific Exhibits

GLEN McCLURE, M.D., Sullivan, Chairman

## VEIN BYPASS SURGERY FOR CORONARY ARTERY DISEASE—IMPROVED TECHNIQS

**Exhibitor:** Harry Siderys, M.D.  
Indianapolis

**Co-exhibitors:** John N. Pittman, M.D.  
Gilbert Herod, M.D.  
John Rubush, M.D.  
Indianapolis

**Attendants:** Harry Siderys, M.D.,  
and Miss P. Linden

Over the course of the last three years we have performed more than 350 vein bypass operations to the coronaries in the treatment of coronary artery disease. Approximately one-half of these patients have had good ventricular function and no complicating factors while one-half have had some evidence of failure of the left ventricle or required concomitant operations such as repair of a ventricular aneurysm or replacement of an aortic or mitral valve. The results are particularly encouraging in those patients who have good ventricular function. However, even those patients with fair ventricular function is good evidence to suggest revascularization is of benefit. Improved surgical techniques and techniques of perfusion have resulted in a gradual lowering of operative mortality for this vein bypass operation. At the present time it approaches mortality for other major surgery not involving cardiopulmonary bypass.

## THE FOUR AREAS OF INVOLVEMENT OF THE INDIANA EASTER SEAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, INC.

**Exhibitor:** Indiana Easter Seal Society for Crippled Children & Adults, Inc.  
Indianapolis

**Attendants:** Thomas L. Thieken,  
James A. Carter and  
Mary F. Elfers

The four areas of involvement of the Indiana Easter Seal Society pictorially presents the basic services provided by the Society. These areas are:

1. Direct Service to the Physically Handicapped
2. Scholarships for Special Training
3. Free Loan Equipment Pool
4. Development Funds for Facilities

## INDICATIONS FOR TOTAL HIP REPLACEMENT ARTHROPLASTY

**Exhibitors:** Charles M. Evarts, M.D.  
Kenneth E. DeHaven, M.D.  
Alan H. Wilde, M.D.  
Carl Nelson, M.D.  
H. Royer Collins, M.D.  
The Cleveland Clinic Foundation, Cleveland, Ohio

**Attendant:** Alan H. Wilde, M.D.

The time-honored goals of reconstructive hip surgery have been to eliminate pain, decrease deformity, increase mobility and stability. Many of the available surgical procedures accomplish one or two of these goals but fall short of total hip prosthetic replacement. A major problem of hip arthroplasty, either mold or endoprosthetic, has been the unpredictability or inconsistency that accompanies these procedures. It has not always been possible to determine what inherent features lead to success or failure in cases that appeared similar at the outset. Certain procedures were destined to eventual failure because of the frequent bilateral hip pathology that is part of severe hip disease. In retrospect, the replacement prosthesis was a natural step in the evolution towards total hip replacement.

The remarkable orthopaedic advances made in total hip joint replacement during the past decade have introduced new surgical dimensions. A careful analysis of the role of total hip joint replacement and its role within the orthopaedic armamentarium is of vital interest to the physician. The indications for total hip joint replacement have evolved as more experience has been gained with this procedure. It is mandatory to recognize that over-enthusiasm for this procedure can easily occur. Proper balance must be maintained utilizing various surgical procedures available for the treatment

of the arthritic hip. The orthopaedic surgeon must maintain perspective while adding total hip joint reconstruction to his armamentarium.

An analysis of Charnley-Muller total hip arthroplasties has been made in order to help determine the indications for this procedure. All patients were evaluated preoperatively according to the Iowa hip evaluation method. The major indications for this procedure are as follows:

1. Marked loss of the bone substance of the acetabular or femoral components
2. Severe bilateral involvement of the hip joints in an elderly patient
3. Failed arthroplasty—cup or endoprosthesis
4. Failed femoral osteotomy

Other indications include failed arthrodesis, failed ring total hip prosthesis, failed Girdlestone arthroplasty, and bone tumors of the proximal femur.

## A VIDEO-CORE CURRICULUM—EDUCATIONAL SYSTEM

**Exhibitor:** Indianapolis Committee on Medical Technology Education, Indiana University Medical Center, Indianapolis

**Attendants:** Robienetta Driver,  
Mary Feeley,  
Bettylyn Hanna,  
Jane Westerman and  
Joyce Ertel

For the Video-Core Curriculum Education System project the I.C.M.T.E. video education exhibit will include an outline of the video curriculum, the tapes, the student guidebooks which accompany each tape and the instructor's manual. Also, we will have continuous play of video tapes on the monitor and video tape recorder, posters and charts describing the system.

These tapes, 20 minutes to 30 minutes in length, are pathophysiological lectures from the hematology and immunology series, of the core curriculum for medical technology education which also includes clinical chemistry, micro-biology, and immunohematology.



## TEN YEARS WITH PERMANENT PACEMAKERS IN A COMMUNITY HOSPITAL

**Exhibitor:** Leonard Gottesman, M.D.  
Cincinnati

**Co-exhibitors:** Flavio Amongero, M.D., and Harold Pescovitz, M.D., Cincinnati

**Attendants:** Any one of the exhibitors

This exhibit consists of three panels. The first panel presents the number of pacemakers with review of the first patients treated including the years from October 1961 to October 1971. The second panel includes the indications for implantation of permanent cardiac pacemakers along with permanent details of techniques. Third is a review of complications and results in the age group of over 75 at the time of original implant. Also, there is a graph indicating longevity with the various generators used. Accompanying the exhibit is a resume of our experience in the form of a printed pamphlet.

## DOUBLE CONTRAST ARTHROGRAPHY OF KNEE

**Exhibitor:** E. M. Cockerill, M.D.  
Department of Radiology,  
Veterans Hospital,  
Indianapolis

**Attendants:** E. M. Cockerill, M.D.  
William Stites, R. T.  
Eugene Bettis, R. T.  
Darral Duncan, R. T.  
Indianapolis

The arthrography exhibit will show a simple accurate method of evaluation of knee injuries and painful or problem knees. The operator must have an adequate knowledge of the joint, the meniscus and the variations of these structures. He must personally supervise the procedure and he must apply a few simple radiographic principles. The limitations of the procedure are usually evident and reflect an inability to adequately visualize the menisci on the films because of faulty technique. There is a tendency to try to over-read or describe the exact type of meniscal fracture when interpretation should be restricted to simple presence or absence of fracture or derangement. There is a distinct hazard in the interpretation of arthrograms performed on postoperative knees and mistakes are relatively frequent.

The material for this exhibit has been collected from approximately 120 arthrograms done during the past three years.

The exhibit will emphasize the simple

accurate technique while pointing out areas of limitation and restricted application.

## MEDICAL CONDITIONS ASSOCIATED WITH ACUTE INTOXICATION

**Exhibitor:** Robert Martz, M.D.,  
Department of  
Toxicology, Indiana  
University School of  
Medicine, Indianapolis

**Co-exhibitors:** Daniel J. Brown, Ph.D.  
Robert B. Forney, Ph.D.

**Attendants:** Dr. Martz, Brown or  
Forney along with other  
members of the Department of Toxicology,  
Indiana University  
School of Medicine

This exhibit will illustrate the many medical problems associated with acute ethanol intoxication. The importance of ethanol as a contributing factor to the occurrence of injuries and the consequence of its presence in many medical conditions will be emphasized. Breath analysis, used as a measure of blood alcohol concentration, will be demonstrated.

## CONSERVATIVE TREATMENT OF POLYPS OF THE COLON AND RECTUM

**Exhibitor:** Horace W. Whiteley, Jr., M.D.,  
Memorial Hospital  
New York, N.Y.

**Attendant:** Horace W. Whiteley, Jr., M.D.

The exhibit describes methods of removing adenomas of the large bowel in safe conservative methods avoiding major surgical procedures whenever possible.

Panel (1) demonstrates the use of up to 50 cm proctosigmoidoscope for removal of pedunculated lesions of the left colon.

Panel (2) shows three methods of local excision of low rectal villous adenomas preserving function. Results of the treatment of 215 villous adenomas of the large bowel are included.

Panel (3) indicates the technique of colotomy—coloscopy for the intra-abdominal diagnosis and treatment of polyps. Our conclusion is that large bowel adenomas can often be safely and satisfactorily treated by conservative means without major procedures.

## "WE CARE ABOUT YOU"

**Exhibitor:** American Association  
of Medical Assistants,  
Inc., Indiana Society

**Attendant:** Neva Y. Arnold, R.N.

Posters and pamphlets will be shown expressing our purpose: Through better educated medical assistants there is a better patient care rendered and a more efficient office, which all results in aiding the busy physician.

## REACH TO RECOVERY REHABILITATION PROGRAM FOR WOMEN AFTER BREAST SURGERY

**Exhibitor:** American Cancer Society  
Marion County Unit  
Indianapolis

**Attendant:** Donna Minnick

Literature and information concerning Reach to Recovery and a display of breast prostheses.

## MENTALLY RETARDED CHILDREN ARE BEING HELPED

**Exhibitor:** Indiana Association for  
Retarded Children  
Indianapolis

**Attendant:** Ilene Younger

Today's mentally retarded children can be tomorrow's useful citizens in the message expressed by photographs of children in learning situations and an adult woman as she takes her time card from the rack to punch in on a job. Pamphlets and information on programs for the mentally retarded will be available.

## PROBLEM ORIENTED PRACTICE

**Exhibitor:** Methodist Hospital  
Family Practice Program  
Indianapolis

**Co-exhibitors:** Roger Pezzuti, M.D.  
William Gilbert, M.D.  
Robert Dicks, M.D.  
Ronald Blankenbaker, M.D.,  
Director of Family Practice Program

**Attendants:** Co-exhibitors

This exhibit will stress the fundamentals of problem-oriented practice and the problem-oriented record. The chart keeping system used at the Methodist Hospital Family Practice Center will be exhibited as well as materials from other sources for comparison. Examples of both inpatient and outpatient problem-oriented records will be presented.

The challenge of more efficient utilization



tion of medical resources demands a more organized and rational approach to record keeping and information retrieval. We at Methodist have attempted to accomplish these ends with the problem-oriented record. We invite your appraisals, comparisons and criticisms.

**ACCELERATION OF WOUND HEALING**

**Exhibitor:** Allan A. Katzberg,  
Department of Anatomy,  
Indiana University  
Medical Center,  
Indianapolis

**Attendant:** Mr. Clyde Rarey

Investigation of the early phases of the wound healing process shows that the connective tissue fibroblasts located at the cut edge will seek to proliferate in a straight line towards the opposing side. In their migration they utilize the fibrin strands of the plasma clot as a scaffolding. Observations with a polarizing microscope reveal the fibrin as birefringent and indicate a reorientation of the protein molecules from a random to a parallel pattern. At the same time the fibrin strands and proliferating cells displayed a mechanical tension sufficient to pull the tissue edges in apposition. There is evidence of a mathematical relationship associated with the development of this growth pattern in that the magnitude of these traction forces varies inversely with the square of the distance between the edges of the tissues.

A number of intrinsic factors contribute to this orientation of growth. However, the entire process may be accelerated by the establishment of a low level electrical field which serves to orient the fibrin strands and the associated migrating cells. This controlled orientation accelerates union and increases the tensile strength of the repaired tissue.

**INDIANA ACADEMY OF FAMILY PHYSICIANS MEMBERSHIP BOOTH**

**Exhibitor:** Indiana Academy of  
Family Physicians  
Indianapolis

**Attendants:** Jackie Schilling, Jackie  
Stahl, Drs. Frederic L.  
Schoen, Ross L. Egger  
and H. M. S. Bristol

The Indiana Academy of Family Physicians membership and organizational exhibit pictures the functions of the Academy relative to the governing body, committee structure and activities.

Membership material will be available for distribution.

**EXCHANGE OF WORLDWIDE SURGICAL KNOWLEDGE THROUGH INTERNATIONAL COLLEGE OF SURGEONS**

**Exhibitor:** William Dannacher,  
M.D., President, Indiana  
Chapter, International  
College of Surgeons  
Wabash

**Co-exhibitors:** Norman Richard, M.D.,  
Regent, International  
College of Surgeons

**Attendants:** Drs. Wm. Dannacher  
and Norman Richard

There are 110 members of the Indiana Chapter of the International College of Surgeons. However, many surgeons are not acquainted with the organization and its worldwide functions. Anesthetists, pathologists and radiologists are also Fellows of the I.C.S.

The International College of Surgeons is purely a scientific organization and takes no part in medical politics or hospital regulations.

The purpose of the I.C.S. is to exchange surgical ideas, knowledge and research on a world wide basis. There are seminars, meetings and postgraduate studies arranged in many foreign countries and medical centers. The International College of Surgeons also provides its Fellows with an "International Surgical Passport" for introduction to foreign hospitals and medical centers when traveling alone or not at a scheduled meeting.

We want to acquaint the doctors in Indiana with the history, functions and purpose of the I.C.A. With the present day popularity of world travel among the medical profession the I.C.S. could be very helpful to many doctors.

**INDIANA HEALTH CAREERS—HEALTH MANPOWER DEVELOPMENT**

**Exhibitor:** Indiana Health Careers,  
Inc.  
Indianapolis

**Attendants:** Dee Hanna,  
Jan Davidson,  
Al Simmons,  
Dennis Dawes,  
Bob Hammond,  
Pam Mangan,  
Lauren Stewart and  
Tom White

Indiana Health Careers is a not-for-profit service organization which counsels young people and adults into the

health occupations field. The basic program is designed to promote a general awareness of the opportunities available. Consultants, trained to motivate and recruit for the more than 250 health occupations, conduct programs in all public schools in Indiana. Free information is made available to anyone upon request.

A special project of Indiana Health Careers is Operation MEDIHC (Military Experience Directed Into Health Careers). This effort is designed to counsel separating military personnel into the health field by cooperating with hospitals and health facilities in utilizing the training and experience obtained by individuals while in the service. Indiana Health Careers was named the official MEDIHC Agency for the state in August 1970, and is rated among the highest in the nation in terms of successful job placement.

Another special project to counsel disadvantaged minority students into the health and allied health field is also administered through the Health Careers Organization. Counselors offer services to the disadvantaged student through special assistance in guidance for education and training programs, financial aid, and the enrollment process.

Recently, Indiana Health Careers has undertaken a comprehensive effort to survey health manpower needs for the state. Data on selected professions is being compiled to more effectively project the requirements for qualified personnel in many areas. Thus, recruitment efforts will be matched more directly to the needs in Indiana.

All projects are interrelated and cooperate effectively to create an adequate base to develop health manpower for the state.

**HEMOPHILIA**

**Exhibitor:** Indiana State Chapter of  
National Hemophilia  
Foundation  
Indianapolis

**Attendants:** Mrs. Katie Milburn and  
James K. Pauley

A four-panel revolving display with photographs, literature and other pertinent information pertaining to hemophilia.

There will be current professional educational brochures available also.



### **SELF INSTRUCTION IN THE I. U. S. of M.**

**Exhibitor:** Indiana University  
School of Medicine  
Indianapolis

**Attendants:** Paul Neel and  
Seldon Bradley

### **REDUCTION OF RISK OF HEART ATTACK AND STROKE**

**Exhibitor:** Indiana Heart  
Association  
Indianapolis

**Attendants:** William R. Dudley,  
Jan I. Koontz,  
David E. Livengood  
and Richard A. Smith

The colorful new exhibit, Reduction of Heart Attack and Stroke, is designed to highlight risk factors and what can be done about them. It includes a list of the risk factors, the parameters of an ideal screening program for the detection of these factors, and steps to be taken as follow-up in their control.

The Indiana Heart Association's "Physician's Time Saver Kit" containing sample publications appropriate for the patient and his/her family will be available to the physicians visiting the exhibit.

### **EMERGENCY MEDICAL ROULETTE**

**Exhibitor:** Indiana State Board of  
Health Emergency  
Medical Services  
Indianapolis, Indiana

**Attendants:** Robert K. Mills and  
Charles R. Hudson

Many lives are lost because our emergency care system is inadequate or too late. Based on the theme of preparedness for any type of emergency or disaster, the exhibit demonstrates that to gamble is to court disaster. The exhibit is designed to appeal to a wide variety of audiences, inasmuch as everyone is concerned with more efficient emergency health care delivery.

Emergency Medical Roulette is a large, vertically mounted roulette wheel powered by a hidden electric motor. By pushing a small button, the wheel starts spinning for a few seconds, then coasts to a stop. An arrow indicates the type of problem the player has "won," thus providing a basis for a short statement on methods to plan for and solve the particular type of problem.

### **MODERN CHILDBIRTH AT HOME**

**Exhibitor:** Joseph Franklin Griggs,  
M.D., Baker, Nevada

**Attendant:** Joseph Franklin Griggs,  
M.D.

A motion picture shows the proper preparation for a modern home delivery, the labor of a mother having her second child, the delivery itself, and how to make an adequate post-partum examination and repair as needed. The mother delivers lying in the lateral position, affording extraordinary photography of the distending perineum. She has been trained in preparation for childbirth, needs no medication or anesthesia, delivers a 4300 gm boy without interference or laceration, retaining excellent sphincter power. The picture shows her joyous exultation and absence of fatigue immediately upon delivery. The father has also been instructed and his helpfulness in labor and delivery is evident. The doctor has the assistance of a nurse-midwife who was trained in England where she did hundreds of home deliveries by herself.

Placards show rationale, indications, contraindications and precautions. Home deliveries are not advocated or encouraged, but this exhibit shows that when home delivery is not contraindicated it can be done with reasonable ease and safety by incorporating modern methods.



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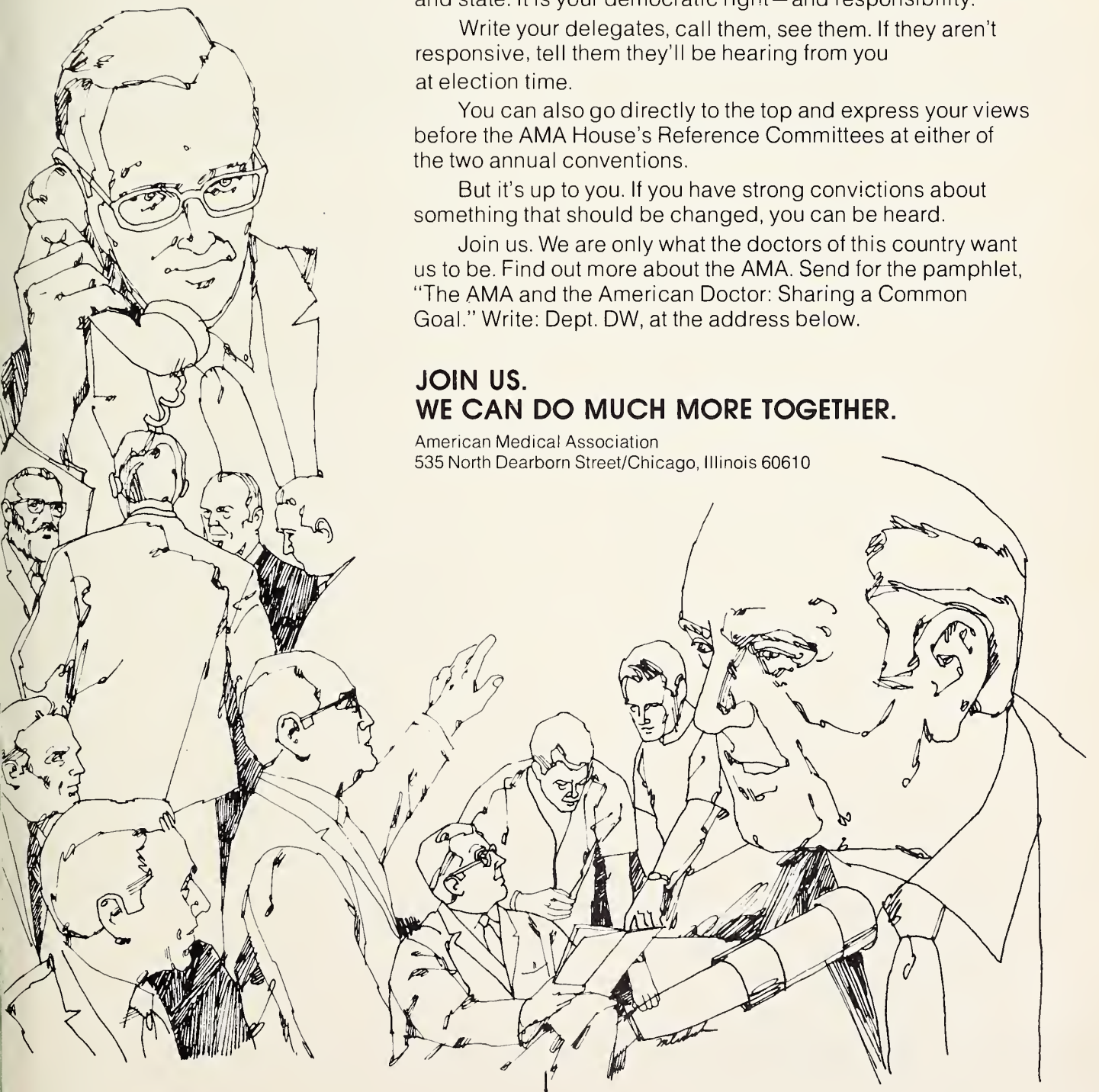
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

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## When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

### **1.2 to 8 grams/day IV dosage range:**

Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections.

In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

### **Effective gram-positive antibiotic:**

Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone





infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

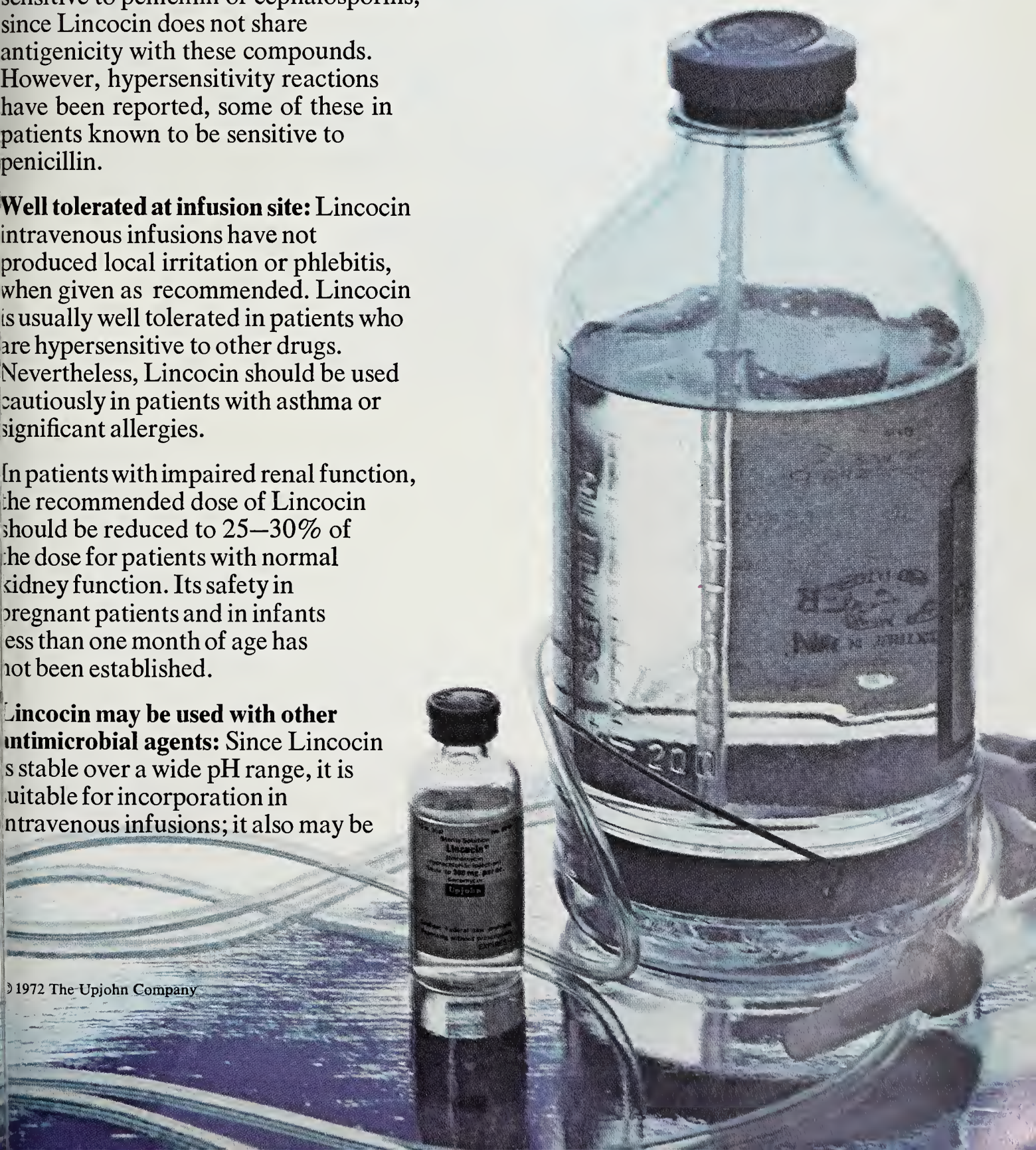
administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin<sup>®</sup>

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.







Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

## (lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections.

Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

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\*Sterile Solution per 1 ml . . . . . 300 mg  
Syrup per 5 ml . . . . . 250 mg

\*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rash, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated in intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg and 500 mg Capsules—bottles of 24 and 100. Sterile Solution, 300 mg per ml—2 and 10 ml vials and 2 ml syringe. Syrup, 250 mg per 5 ml—60 ml and pint bottles.

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**General Practitioner's Duty to Seek Consultation**—A general practitioner's duty to seek consultation arises only when he knows or reasonably should know that such consultation is indicated, a Texas appellate court ruled. Consultation is not required on every possible complication, the court said.

A man was taken to a hospital emergency room because he was nervous and shaky. His wife said that he had been having hallucinations. She allegedly indicated that he had been drinking heavily.

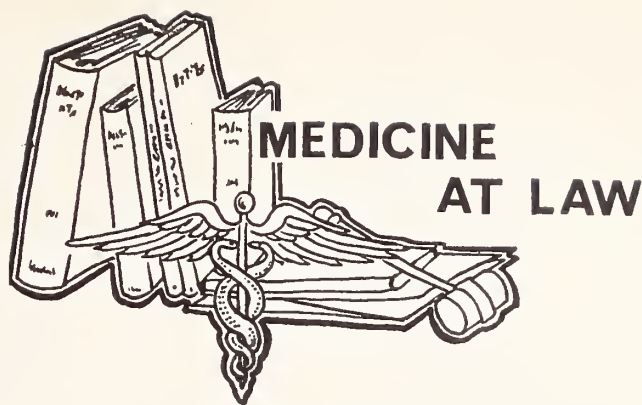
The patient was examined by a general practitioner, who was not his family physician. The physician made a diagnosis of "alcoholism DTs." He hospitalized the patient and ordered sedatives.

The next day the patient was restless and having hallucinations. He bumped his head in his room, suffering a small cut above his eyebrow. When the physician saw him at 8:30 a.m., the man was in a comatose condition.

At 3:00 p.m., a nurse reported that the patient had not eaten. The physician then ordered intravenous feeding. The man's pulse was slow and irregular. The nurses noted that his respiration was short, rapid at times, and becoming slower. At 7:00 p.m., the physician consulted a neurosurgeon. The patient died at midnight.

An autopsy revealed that the patient had had a hematoma for more than 48 hours. The pathologist indicated that the man's liver was in a condition consistent with alcoholism. He attached no significance to the cut above the man's eyebrow.

The patient's widow and children sued the general practitioner and the hospital. They claimed that the physician negligently failed to obtain consultation and failed to take a complete history. They claimed that the hospital had negligently failed to restrain the patient. No expert testimony was introduced as



to the standard of care of a reasonably prudent physician in such circumstances.

The jury found that, although the physician had failed to take a complete history, this was not negligent. The jury did not return a verdict as to the failure to call in a specialist.

The jury did return a verdict which the court held to be sufficient to absolve the hospital of negligence. The trial court entered judgment in favor of the physician and the hospital. The widow and children appealed.

Affirming the judgment, the appellate court noted that there was no evidence that the physician had violated any standard of care. A general practitioner is not required to consult a specialist on every conceivable complication that might arise, the court said. A physician's duty to seek consultation must be established by the standards of his profession.

Although the physician failed to take a complete history, the court noted that there was no medical testimony that this failure caused the man's death. Without such proof, the court ruled that the physician could not be held liable.

There also was no proof that the patient's alleged fall in the hospital caused his death, the court held. The court noted that the pathologist had attached no significance to the cut above the man's eyebrow.—

*Chasco v. Providence Memorial Hospital*, 476 S.W.2d 385 (Tex. Ct. of Civil App., Jan. 12, 1972).

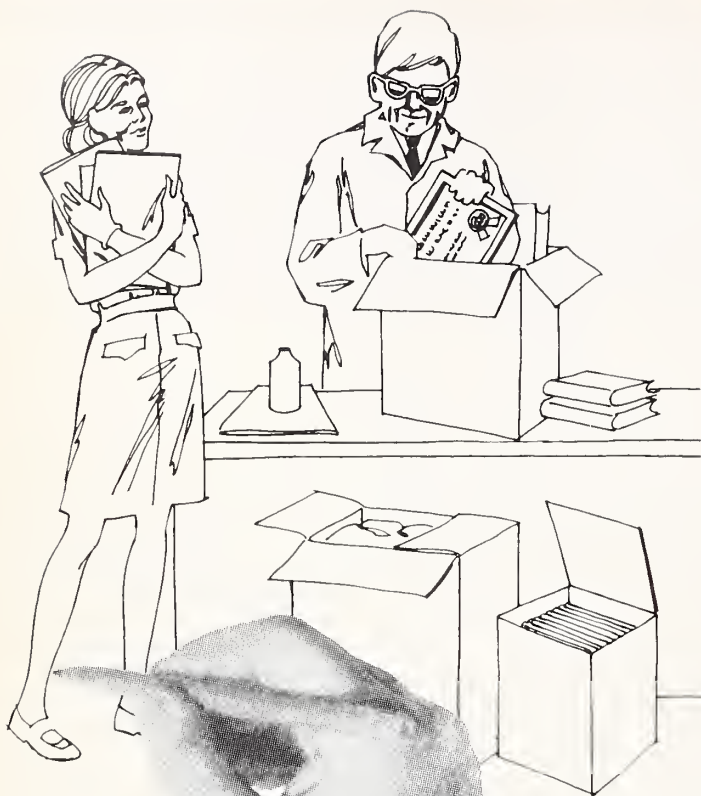
**Price Commission Ruling on Hospital-Based Physicians**—A hospital-based radiologist is subject to the same Economic Stabilization Regulations applicable to noninstitutional providers, the Price Commission recently ruled.

The radiologist had entered into a contract with the hospital. He derived all his income from the contract with the hospital. The hospital exercised no control over the medical services rendered by him.

The radiologist requested a 5½ per cent increase in his compensation. The Economic Stabilization Regulations limit noninstitutional providers to a 2½ per cent increase in fees, and then only when based on allowable costs.

Hospital-based physicians under contract with hospitals are not subject to the direction and control of the hospital, the Commission noted. Such physicians are independent contractors, not employees, the Commission said. As independent contractors, they are subject to the restrictions on noninstitutional providers. Therefore, any increase in their compensation must be limited to 2½ per cent and must be based on allowable costs, the Commission held.—*Price Commission Ruling 1972-119* (April 4, 1972)





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## ABSTRACTS, BOOK REVIEWS

### THE FUNDAMENTAL MECHANISMS OF SHOCK

L. B. Hinshaw and B. G. Cox, Vol. 23, *Advances in Experimental Medicine and Biology*, Plenum Press, 1972, \$22.50.

*The Fundamental Mechanisms of Shock* is Volume 23 in a series on *Advances in Experimental Medicine and Biology*. Although the work largely presents experimental data, its subject, of course, represents a problem with deep interest for surgeons, physiologists, internists, immunologists, and biochemists. Much of the subject matter deals with endogenously released vasoactive agents. Major sections in the book cover shock and the cardiovascular system, shock and metabolism, and toxic factors in shock. The book encompasses some 450 pages photoprinted from a typed manuscript. It is recommended for physicians with a particular interest in the investigative aspects of shock. The book has numerous attractive illustrations, including photographs, diagrams, and flow charts. It is bound in an attractive hard cover.

W. D. SNIVELY, JR., M.D.  
Evansville

### NATURE AND NURTURE IN ALCOHOLISM

Symposium in *Annals of N.Y. Academy of Sciences*; Vol. 197, May 1972; 229 pages with numerous tables and references.

In these days of busy preoccupation with heroin addiction, "ups" with the Dexies and "downs" with the barbiturates—to say nothing of hashish and such—it is worth while having a symposium on the oldest (and most prevalent and deadly) precursor of the ancestor of the mood changing drugs: Alcohol, ethanol and all its brood of congeners. In these United States of ours we forget that the *Per capita* consumption of distilled spirits is almost *two* gallons per annum: We (all of us) spend some 13 *billion* dollars on these alcoholic drinks, each year.

This very brisk and down-to-earth gathering of authorities in the field discussed such basic problems as the biochemical and genetic causes of chronic alcoholism. What do the children of alcoholics inherit? Which enzymes do what? What happens to the offspring of alcoholic mothers? Is homosexuality a factor? Is there possible a psychological interpretation of alcoholism? What do cross-cultural and interethnic explorations reveal?

Altogether, a most sobering and revealing illumination of a still largely unknown (and ignored) area of our daily lives. It does tell us, just a little, why fully one half of our auto fatalities (30,000 annually) have a documented alcoholic background. The symposium is *not* a sermon but it surely could be used for one.

ARNOLD LIEBERMAN, M.D.  
New York



REVIEW OF MEDICAL PHYSIOLOGY

William A. Ganong, M.D., Lange Medical Publications, Los Altos, Calif., 1971, Fifth Edition; 538 pages; \$8.50.

This is not a medical school textbook but an up-to-date and comprehensive reference of mammalian and human physiology. The author is professor of physiology and chairman of the Department of Physiology at the University of California School of Medicine, San Francisco. It is divided into 40 sections dealing with the various systems of the body. The material is clarified by photographic reproductions and pen sketches. Also included are several complete tables of atomic weights, English and metric weights and measurements, and ranges of normal values in whole human blood plasma and serum.

Because of its modern review of every system of the body, it should be of much interest to all in the practice of medicine regardless of their special field of practice.

It is bound in flexible, water resistant material. Although the subject matter is somewhat profound, it is clearly written and is enjoyable reading.

The book is not priced out of line and should be in every medical library, especially those used by students. It is written for those who have some knowledge of anatomy and chemistry.

DAVID A. BICKEL, M.D.  
South Bend

INTEGRATIVE ACTIVITY OF THE BRAIN

Jerzy Konorski, M.D., Professor of Neurophysiology, Nencki Institute, Warsaw, Poland, University of Chicago Press, 1970; 13 chapters, 530 pages; appropriately illustrated and well indexed, several color plates.

The English version of this work was apparently prepared by Professor Konorski himself. That is most commendable. Rather obviously—almost too much so—the title is derived directly from Sherrington's "The Integrative Action of the Nervous System"; in fact, the very first reference of the introduction is to that volume. The author was a student of THE I. P. Pavlov, who also had a monograph with a similar title. One cannot cavil this.

The audience being addressed seems to fluctuate: is he lecturing M.D.s-to-be, college biology students, graduate neurophysiology candidates for a Ph.D.—or just whom? In future revisions this should be brought into a single focus. Also, there are an amazing number of typo errors, poor binding (plate inversions and such), etc. Interestingly enough, the original Russian (and Polish) names set in the Cyrillic alphabet are—of all things—often misspelled; obviously, the author just did not bother to proofread!

Also, the author has the portentous habit of using long words where the shorter are more familiar to the reader. As an example, on page 164, reference twenty-two is to "semiology"—a literal translation. We prefer to talk of "symptomatology," a much better termin. In plain English, I'm pleading with the author to have the next updating scrutinized by a person whose native language is just that: English. (I'm looking at an elegant volume—also translated from a foreign tongue, "Biology of Memory". The review is in JISMA, Jan. 1972.)

It may be that I'm a carping critic; still, I think that this work deserves a careful revision along lines I've just indicated. Basically, it is a sound monograph deserving wide dissemination.

ARNOLD LIEBERMAN, M.D.  
New York

SLEEP AND WAKEFULNESS

Nathaniel Kleitman, Ph.D., revised and enlarged edition, University of Chicago Press, Chicago; 550 pages, over 4,300 references; \$12.50.

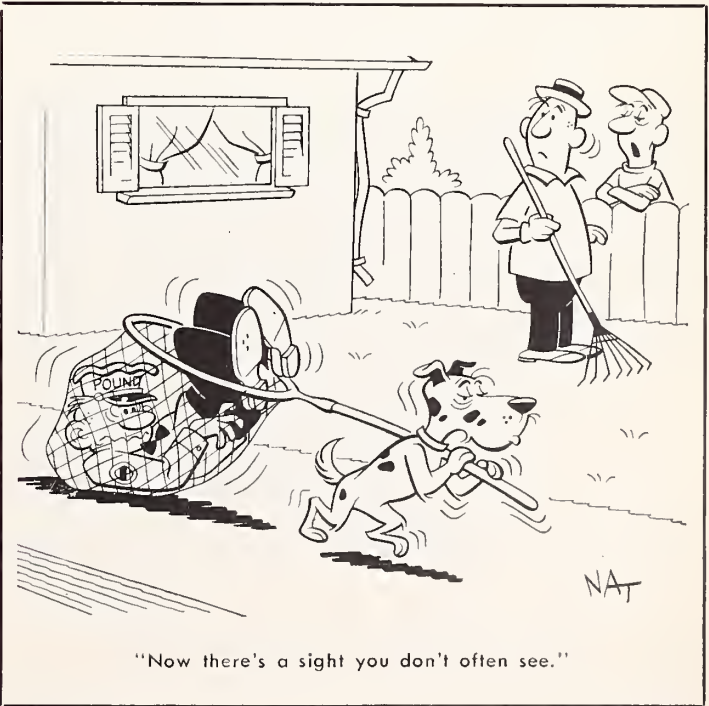
This is the magnum opus of a dedicated professor of physiology who devoted his entire professional career to the single topic: Sleep. As a medical student at the University of Chicago, I became one of Dr. Kleitman's guinea pigs as he pursued the seemingly, oh, so innocent and seemingly oh so simple subject of, yes, Sleep. As an offshoot of my interest, I devoted time and effort (after getting my M.D.) to some research in physiology that—eventually—produced a Ph.D. for me in that field.

The present volume has to be perused to be appreciated. One cannot really do justice in a brief review to this all-encompassing overview, in all of its ramifications, of the whys and wherefores of Sleep. The cyclic nature of the phenomenon—the effects of the dark-light alternations—the fatal consequences of continuing sleep deprivation—the basic pharmacology of hibernation, hypnosis, narcolepsy, cataplexy, epilepsy, insomnia—sleep abnormalities and disturbances—one can only catalogue the vast roll of chapter heads and allow the intrigued reader free rein to delve into those topics that are of interest to him.

The language used is consistently clear, crisp and incisive. The author comes straight to the heart of the matter without dallying on the way. The type and printing are excellent. In my reading, I failed to find as much as a single typographical error. The price is more than modest.

Long after we are all gone this monograph will survive as a testimonial to the modest author. It is a pity that we no longer have a specific Department of Physiology at the great U. of C. In our hurry to produce instant doctors, we have stopped studying in depth the *normal* human being. Can we really go on to examine the pathology of disease without knowing the normal?

ARNOLD LIEBERMAN, M.D.  
New York





## Abstracts from Various Literature, Prepared by AMA

### MORTALITY FROM CORONARY HEART DISEASE DURING PHENFORMIN THERAPY

M. Tzagournis (Ohio State Univ. Hosp., Columbus 43210)  
and R. Reynertson

*Ann. Intern. Med.* 76:587-592 (April) 1972.

A group of 137 patients with premature coronary disease was treated with phenformin plus diet or diet alone. Twenty-five of the 137 patients (18%) died during the study. There were nine deaths among 54 patients on diet (17%) and 16 deaths among 83 taking phenformin (19%). There was no significant difference in cumulative survival between the two groups.

### DRUG PRESCRIBING AND USE IN AMERICAN COMMUNITY

P. D. Stolley et al. (Johns Hopkins School of Hygiene and Public Health, Baltimore 21205)

*Ann. Intern. Med.* 76:537-540 (April) 1972.

Psychotropic drugs accounted for 17% of all prescriptions, with almost 13% of all patients receiving one of these agents through a doctor's prescription. The amphetamines were the eighth most frequently dispensed class of drugs, with almost 3% of all patients who received a prescription being given an amphetamine.

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### RANDOMIZED DOUBLE-BLIND TRIAL OF FOUR ORAL PROGESTAGEN-ONLY CONTRACEPTIVES

M. P. Vessey et al. (Radcliffe Infirmary, Oxford, England)  
*Lancet* 1:915-922 (April 29) 1972.

A randomized double-blind trial of four progestagen-only oral contraceptives was carried out in 307 women (megestrol acetate, norethisterone acetate, chlormadinone acetate, and norgestrel). A fifth group of 71 women received a combined oral contraceptive (ethinyl estradiol and megestrol acetate). Pregnancy rates were 2/100 woman years for norethisterone acetate and norgestrel, 4/100 for chlormadinone acetate, and 13/100 for megestrol acetate. Norgestrel was the most unsatisfactory preparation and norethisterone acetate was found to be as acceptable as the combined oral contraceptive.

### BIOLOGICAL EFFECTS OF SIMULATED HIGH ALTITUDE CLIMATE IN PRESSURIZED COMMERCIAL PLANES ON PASSENGERS AND FLYING PERSONNEL

S. W. Tromp (Biometeorological Research Center, Leiden, The Netherlands)

*Aerosp. Med.* 43:446-449 (April) 1972.

In most commercial planes the simulated altitude in the cabins surpasses the 1,500 meter altitude boundary. After a stay of several hours, an improved lung ventilation and vital capacity can be expected, increased peripheral blood flow, increased sensitivity of the autonomic nervous system, stimulation of the hormonal production of the adrenal gland and of the blood producing mechanisms, improvement of the overall thermoregulation efficiency, increased sensitivity to drugs and toxic substances, and explosive developments of latent infectious disease. Apart from such things as biological rhythm disturbances, emotional stresses, and irregular working hours, a commercial flight with a simulated altitude in the cabin of 1,600 meters (4,800 ft.) is very healthy, both for passengers and flying personnel.

### OCCURRENCE OF EPIDEMIC INFECTIOUS HEPATITIS IN CHRONIC CARRIERS OF AUSTRALIA ANTIGEN

D. E. Dietzman et al. (National Institute of Neurological Diseases and Stroke, Bethesda, Md. 20014; *J. Pediatr.*, 80:577-582 (April) 1972)

During a major institutional epidemic of infectious hepatitis, chronic carriers of Au SH were identified and found to be susceptible to infectious hepatitis. This observation provides additional evidence that serum hepatitis, which has been associated with Au SH and infectious hepatitis, which is not associated with the antigen, are immunologically dissimilar and caused by different etiologic agents.



# Utilization Review by Indiana Blue Shield Guards Against Unwarranted Claims

Each month, Indiana physicians, hospitals and other providers of care submit thousands of health care claims for processing by Indiana Blue Shield. These claims are then studied through a program known as Blue Shield Utilization Review. Its purpose is to detect, prevent and eliminate any errors and abuses that can result from unwarranted claims payments. When errors are found and corrected, this helps to conserve membership funds, and providers of care benefit, too.

Utilization Review has shown that the vast majority of today's Indiana physicians are competent and professional in their work. This year, the Professional Relations Staff of Indiana Blue Shield continues to educate the professional community, emphasizing both the high competence of most physicians, as well as pointing out those few problem areas which seem to deviate drastically from the norm.

Dr. Glen V. Ryan, Medical Advisor and former chairman of the Blue Shield Board of Directors, has said that "Utilization Review activities are expected to provide a bonus effect in both the cost and quality of medical care by reason of a deterrent factor which will become greater as physicians and the public become aware of its capabilities."

Until 1970 Utilization Review was limited to an entirely manual study of paid claims for medical practice in hospitals. But computer applications have expanded this review to now include paid and pending claims for the approximately 12,000 total providers in Indiana.

In addition to supplying data to resolve claims problems, a major goal of Utilization Review is to make a wealth of medical claims data available to providers at all times. The data now available to providers is generated by a series of sophisticated computer reports which summarize and objectively interpret patterns of practice for each category of provider.

The claims review system includes four phases: detection, investigation and analysis of data, disposition, and education.

The detection phase is designed to note four basic types of errors:

1. providers making inadvertent mistakes, such as placing a wrong code number on a claim form;
2. providers who perform unnecessary services;
3. providers who report services never performed;
4. Blue Shield members who misuse or abuse medical services.

To detect a possible claims error, procedures performed by a given physician are compared to similar ones rendered by other physicians in his area and throughout the state. If a physician deviates from a normal practice pattern, those claims related to that pattern are flagged by the computer as possible errors to undergo further study.

When further study is needed, an effort is made to collect

all available facts concerning the case. Hospital records, physician's office records, patient interviews and questionnaires are employed. These external data sources are gathered together with internal information from statistical claims experience profiles.

When a possibility of error or abuse exists, the problem is channeled to Blue Shield medical advisors. If advisors have reason to question the case, a letter is sent to the physician informing him of the problem and requesting clarification. Also, when necessary, research is conducted by Blue Shield Professional Relations personnel.

If abuse appears evident, the case is given to Blue Shield medical advisors. Upon their recommendation the case may be referred to the county medical society, or the state medical association for review, recommendation or action. Cases involving outright fraud may, after a review by legal counsel, be referred to the District Attorney's office.

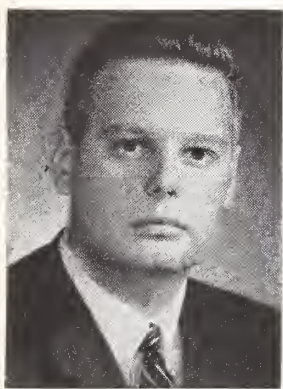
When a member is responsible for misuse of his Blue Shield coverage, personal meetings are arranged with the member or his employer. If the member has created a serious utilization problem, the employer will be asked to take corrective action. If the member is involved in fraud, the case will be referred to legal counsel for presentation to the District Attorney.

According to Herbert P. Dixon, vice president of Blue Shield's Professional Relations in Indiana, "the use of Utilization Review data should enable Blue Shield and the medical profession to work together more closely than ever before in achieving our common goal of providing the best medical care at the lowest possible cost to the consumer."



REVIEWING a claim are: Mrs. Mary Myers (left) Blue Shield senior medical advisor; Dr. Glen V. Ryan, Blue Shield medical advisor and former chairman of the Board of Directors; and Miss Bertie Howe, senior medical advisor.





# TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

ANY professional persons are stunned when they realize what they earn on an hourly basis. If you work 40 hours per week, with a two-week vacation per year, then your hourly rate (at various net profit levels) is as follows.

Net Profits	Hourly Rate
\$10,000	\$ 5
12,000	6
14,000	7
16,000	8
18,000	9
20,000	10
22,000	11
24,000	12
26,000	13
28,000	14
30,000	15
40,000	20
50,000	25

Recently, the Tax Court had words for a dentist who competed in boat races and deducted the ex-

penses of operating the boat as dentistry business expenses for federal income tax purposes. The Court stated: "Moreover, petitioner has not shown any proximate relationship between his boating and entertainment expenses and his business, i.e., the practice of dentistry. The most that petitioner has shown is that he received publicity from his boat racing, that he became acquainted with some of his current patients through his sailing and entertainment activities, and that physicians and dentists whom he met through these activities have referred patients to him. This evidence falls short of showing that the boating and entertainment expenditures were so closely related to the conduct of his business as to have been appropriate, helpful, usual, or necessary. We think the physicians and fellow dentists referred patients to him, and the patients came to him for dental services, not because they knew that he had won some sailboat races, but because he had earned the reputation of being a professionally competent dentist through rendering satisfactory services to his patients.

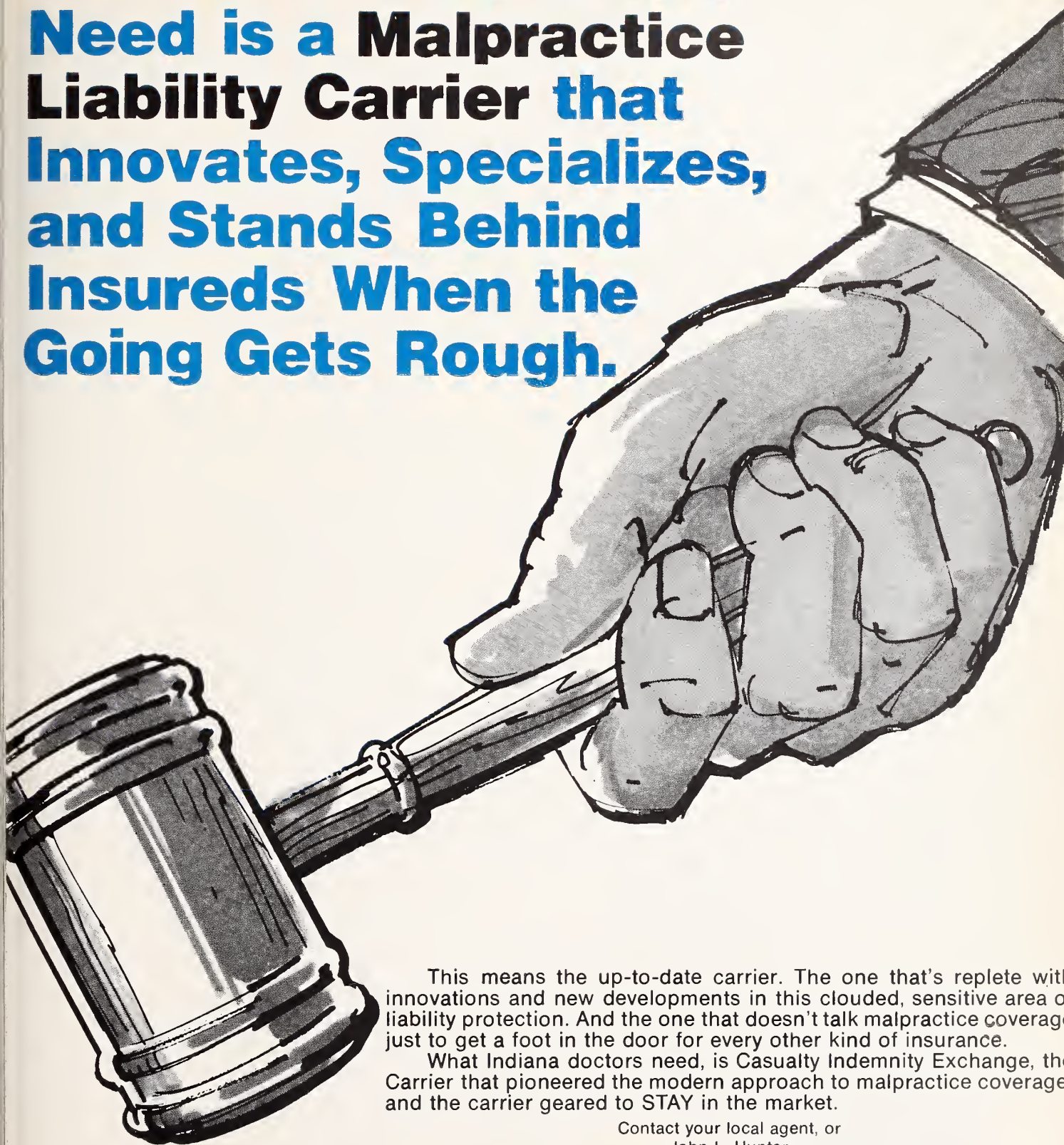
"While petitioner's sailing and related social activities may have helped him create friendships which have resulted in some indirect benefits to his practice, such could be true of any social relationships. We do not question the value of the cultivation of social contacts—business, personal, or political—to a person engaged in a profession, business, or other employment. A doctor may bring himself to the attention of members of his community by participating in political activities; a bricklayer may ingratiate himself with his foreman by joining his bowling league; or a lawyer may become actively involved in the civic work of his favorite club. However, even though some indirect benefits may be realized, the expenses resulting from such ac-

tivities are not deductible because they do not have a sufficiently close relationship to the operation of the taxpayer's business."

The Tax Court has just issued a decision that is one of the most significant decisions that relate to Subchapter S corporations. In a nutshell, the Tax Court held that the failure of a new shareholder to consent to a Subchapter S election will not automatically terminate the Subchapter S election if the transfer of shares to the new shareholder is a sham. In this case, the transfer was to the corporation's lawyer. This case should be read by anyone who is about to terminate a Subchapter S election. Frequently, a Subchapter S election is terminated for one of two reasons, i.e., to avoid a year-end constructive dividend, or, to avoid the recently imposed limitations on the effect of contributions to qualified retirement plans. Obviously, if the attempted termination is unsuccessful, then there may be a constructive dividend, and shareholder-employees may be taxed, for income tax purposes, on some of the contributions that the corporation makes to the corporation's qualified retirement plans. Worse yet, if profit sharing plans of Subchapter S corporations do not have certain provisions in them (which are required by the Tax Reform Act of 1969), then the plans will be **disqualified**. And, frequently, these provisions will not be inserted in plans if the corporation intends to terminate the Subchapter S election during the year that the corporation establishes the retirement plan. Thus, take care when you attempt to terminate a Subchapter S election. Make certain that there are sound economic reasons for the termination and for the method used to bring about the termination, be it by a transfer of shares to a nonconsenting shareholder or by an issuance of a second class of shares.



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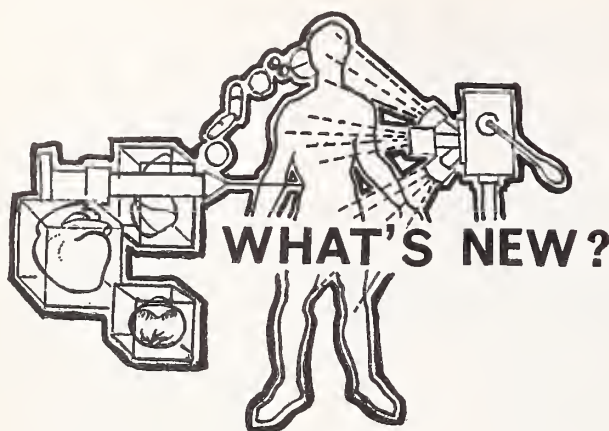
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West Chemical has developed a simple device for protection of fingers while breaking open glass ampoules. It consists of a flanged sheath which covers the small end of the ampoule and prevents contact of the finger with any part of the glass during the snapping off process. The device is economical, reusable and sterilizable.

\* \* \*

Lexington Instruments has issued a new updated data sheet on their Lex-O<sub>2</sub>-Con, the instrument which does a complete oxygen content measurement in five minutes. A sample of blood is injected into the instrument, the start button is pushed and five minutes later the oxygen content is presented in volumes percent in direct digital reading.

\* \* \*

Castle has a new table top steam sterilizer suitable for use in physician's offices and clinics. The chamber is 9" in diameter and 16" deep and will sterilize wrapped or unwrapped instruments, utensils, packs, solutions and dressings. It operates with an automatic cycle.

\* \* \*

Searle Diagnostic announces a screening test for hyperlipemia that can detect elevated serum lipid levels in less than 15 minutes and at a very low cost. Called TEKIT® Precipitest™ LP, it requires 200 microliters of human serum. The test requires only a single reagent and no special equipment. It indicates whether hyperlipemia/hyperlipoproteinemia exists. It also indicates which lipid fraction is elevated and whether the condition is hyperlipoproteinemia Type II.

\* \* \*

Ortho-Kinetics has an entirely new therapeutic chair for handicapped children. It has all the features and adjustments necessary to aid and comfort children from two through 16 years of age and up. It reduces the strain, work and time required in caring for the handicapped child.

\* \* \*

News of what is new in the medical supply industry is camouflaged of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

## Pre-Sate® (chlorphentermine HCl)

**CAUTION:** Federal law prohibits dispensing without prescription.

**Indications:** Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e., several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

**Contraindications:** Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monoamine oxidase inhibitors, since hypertensive crises may result.

**Warnings:** When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

**Drug Dependence:** Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

**Usage In Pregnancy:** The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

**Usage In Children:** Not recommended for use in children under 12 years of age.

**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

**Adverse Reactions: Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

**Dosage and Administration:** The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

**Overdosage: Manifestations:** Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

**Management:** Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

**How Supplied:** Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request.



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atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	( $\frac{1}{4}$ gr.) 16.2 mg.	( $\frac{1}{2}$ gr.) 32.4 mg.	( $\frac{3}{4}$ gr.) 48.6 mg.

(warning: may be habit forming)

**Brief summary.** Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.



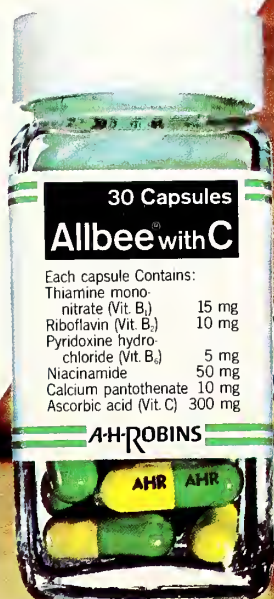
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## FUTURE MEETINGS, SEMINARS, COURSES

### OB-GYN District V Meeting Set For Oct. 5-7 at Indianapolis

"What's New in Obstetrics-Gynecology" is the theme of the District V, American College of Obstetrics and Gynecology, to be held October 5-7 at the Indianapolis Hilton.

Guest speakers will be: Dr. Watson Bowes, University of Colorado, whose subjects are "Prenatal Diagnosis of Genetic Disorders" and "Assessment of Fetal Risk, Fetal Maturity and Timing of Delivery"; Dr. William E. Brenner, University of North Carolina, speaking on "Current Status of Prostaglandin Research" and "Newer Concepts in the Management of Labor"; Dr. John L. Lewis, Memorial Hospital for Cancer & Allied Diseases, discussing "Chemotherapy of Gynecologic Cancer"; Dr. Bradley Smith, Vanderbilt University, discussing "Hazards of Anesthetics to Patients and Personnel" and "Management of Anesthesia and Resuscitation of the New-born"; and Dr. Horace Thompson, Denver General Hospital, who will talk on "Ultrasound in Obstetrics and Gynecology" and "Newer Concepts in Female Sterilization."

The Saturday morning program is entitled "What's New with the Fetus." This will be a combined session with the District Nurses.

The annual golf tournament again precedes the meeting.

### "Frontiers" Series Announced

The University of Chicago announces the eighth series of "Frontiers of Medicine", which consists of nine programs presented, one each month, starting in September. The program is acceptable for 27 1/4 credit hours by the American Academy of Family Physicians. A fee of \$100 covers the entire series, single sessions are \$15. The 1972-73 schedule is given below. For full information write Frontiers of Medicine, 950 E. 59th St., Chicago 60637.

September 13: "Male and Female Infertility."

October 11: "Recent Progress in the Management of the Complications of Streptococcal Infection."

November 8: "Virology in Medicine."

December 13: "Mind-Body Interaction."

January 10: "Advances in Coronary Heart Disease."

February 7: "Modern Clinical Approaches to Gastrointestinal Bleeding."

March 7: "Nutrition in Prophylaxis and Therapy."

April 11: "Advances in Neurological Diagnosis and Treatment."

May 9: "The Acutely Injured Patient."

### Montreal to Host PG Course

A Postgraduate Course in Gastroenterology will be conducted by the American College of Gastroenterology in Montreal, Canada, on October 19, 20 and 21. The course is open to all physicians. The registration fee for non-members is \$100. Write the College at 299 Broadway, New York 10007.

### Medical Systems Conference Set

The Fourth Annual Conference of the Society for Advanced Medical Systems will meet at the Marriott Hotel, Saddle Brook, N.J., October 29 to November 1. All interested physicians are invited to attend. Dr. Lawrence Weed of the University of Vermont will give the keynote address. Copies of the program and registration forms may be obtained by writing Mrs. Patricia Horner, Executive Secretary, Suite N-300, 3900 Wisconsin Ave., N.W., Washington, D.C. 20016.

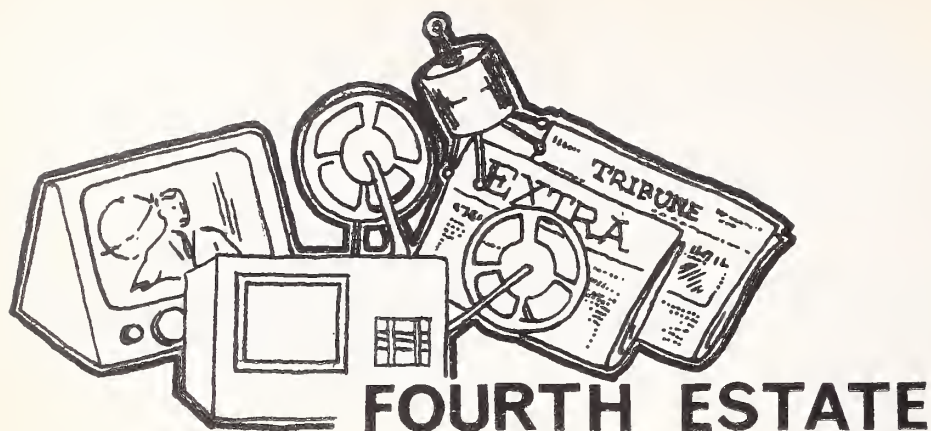
### Set Cardiology Symposium

The Borgess Hospital of Kalamazoo, Mich., announces its Third Annual Cardiology Symposium, "Cardiology for the Practitioner," on November 9 and 10. It will feature nationally known speakers. All interested physicians are invited. Write Dr. Roberto Barcala, 1521 Gull Road, Kalamazoo, 49001.

### ICS to Conduct Congress

The International College of Surgeons will conduct the Fifth Western Hemisphere Congress November 12 to 16 at the Town & Country Hotel Convention Center in San Diego. For details write the Congress at 136 N. Brighton St., Burbank, Calif. 91506.





This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

### Dr. Eggers' 26 Years

Dr. Henry W. Eggers' 26 years on Hammond's school board add up to an achievement of considerable note.

The number of years alone is noteworthy and measures the esteem those who voted in school board elections held for the busy physician. For one in his profession to burden himself with such a time-consuming and virtually non-remunerative undertaking itself is laudatory.

Especially commendable is the insistence on progress that char-

acterized his tenure. He used the responsibilities he sought for the benefit of education. How different from the resistance to change, the personal aggrandizement and power that so many seek from public office and which they handily acquire as their entrenchment deepens.

It must not go unnoticed either that school board service is one of the toughest in government as well as one of the most awesome at the local level. The dedicated board member literally gives of himself at considerable personal and family sacrifice. It is possibly one of the

few public offices remaining that is truly citizen-oriented when fulfilled with the integrity shown by Dr. Eggers.

Interestingly, we're told that Dr. Eggers rather boxed himself into the school board rat race. His casual comment about the dearth of those sincerely interested in public service—an observation that reflected a personal conviction—drew the suggestion that he ought to practice what he was preaching by running for the school board.

Because he did, Hammond's schools benefited. — *Hammond Times*, July 11, 1972.

### Reproduction of July "Peace" Cover Available

Requests for reprints of the July cover painting by Dr. Wei-Ping Loh have been so numerous that an overrun has been ordered and anyone who has not yet requested a copy may obtain one by sending in the postal or writing to THE JOURNAL, 3935 N. Meridian St., Indianapolis, IN 46208.

It is anticipated that the prints will be mailed on or before September 15, 1972.



# 7 cars for 7 brothers.

Wyatt paints Mother Nature. To carry his paints and canvases around with him, he needed a car with a large trunk. The Audi has the same amount of trunk space as the Lincoln Continental Mark IV. This amazed Wyatt since the Audi is much shorter than the Lincoln.

Bernard has a problem. Not only doesn't he take care of himself (a button missing here, a cuff link lost there), he doesn't take care of his car either. No wonder he wanted a car that gets the expert service of a Volkswagen. The Audi does because it's part of the VW organization. (Now if we could only get Bernard to take care of himself.)

Since Edgar has a big family

(a boy, a girl, a wife, and a mother-in-law who likes to go for rides), he needed a car with lots of room. The Audi has just about the same headroom and legroom as the Rolls-Royce Silver Shadow. (Edgar sees a lot more of his mother-in-law now.)

Rolf is a first-class skier. He gets to where he's going because the Audi, like the Cadillac Eldorado, has front-wheel drive to give him the traction he needs to get through the snow to the snow.

Fishing, camping and taming the rapids are Duke's way of life. He wanted a car that could handle mountain roads and get him up to

his cabin comfortably. Because the Audi has independent front suspension like the Aston Martin, Duke gets peace of mind as well as peace of body.

Meet Geoffrey the banker. To impress his associates, he wanted a car with a plush interior. Since the Audi's interior bears such an uncanny resemblance to that of the Mercedes-Benz 280SE, Geoffrey is now a Senior Vice-President.

Nothing pleases Lance more than pleasing women. He knows the fuss they make over racing car drivers. He also knows the Audi has the same type of steering system as the racing Ferrari. (Ursula is now in seventh heaven.)



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## Dr. Farquhar Visits Russia

Dr. John Farquhar, Fort Wayne, visited Russia in July—at the invitation of President Nixon—where he studied emergency medical services in the Soviet Union. Dr. Farquhar heads St. Joseph's Emergency Department Service and is a member of the ISMA Commission on Emergency Medical Services.

## Inhalation Therapy Manual Offered

"Tentative Manual for the Home Use of Inhalation Therapy" is a 20-page manual published by the National Fire Protection Association. It is for the guidance of patients and their families as well as therapists, visiting nurses and members of fire prevention bureaus. It emphasizes prevention of fire hazards and the proper fire fighting technics when oxygen equipment is involved. Copies are available at \$1 each. Write the Association at 60 Batterymarch St., Boston 02110.

## Doctors' Aid Needed in Study Of Medical Device Hazards

A broad variety of hazards are associated with the over 5,000 different medical devices in use today. Physicians, nurses and administrators are expressing increasing concern over both the safety and the efficacy of clinical equipment. The Emergency Care Research Institute of Philadelphia, a nonprofit agency, is undertaking a comprehensive study of this problem with the support of the Office of Medical Devices of the Food and Drug Administration.

A detailed index will be compiled of injuries, complications and deaths associated with the improper design, manufacture, maintenance or use of all types of medical instruments, devices and systems. Hazards or inadequate performance in diagnostic and therapeutic devices found in hospitals, clinics, nursing homes, private medical offices, aid stations, ambulances and homes and used by health professionals, paramedical personnel or lay people, are being investigated.

Health professional and paramedical personnel are urged to contribute information in support of this continuing program to improve safety. All contributors may be assured that each problem will be investigated and resolved and will receive a complimentary copy of the final report. If you have ever encountered or do ever encounter a medical device which you feel is directly or indirectly responsible for injury or death to either a patient or the user, please notify ECRI by letter or telephone. Only information related to the device is necessary. Identification of your institution is not necessary unless you or your institution wish technical assistance in resolving a current problem or recognition for your assistance. The needed information includes:

1. Type of device (e.g., electrocardiograph, oxygen-powered resuscitator, heart valve, wheel chair, surgical dressing, etc.)
2. Mode of injury and effect on patient or user (e.g., laceration of hand by sharp-edged equipment housing, tissue reaction to implanted pacemaker, ventricular fibrillation and death due to electric shock by patient monitor, thrombosis and infection due to venous catheter, perforation of the uterus by IUD, etc.)
3. Cause of problem if identified with reasonable certainty (e.g., operator error in using defibrillator, broken plug and frayed electrical cord, microwave oven inhibition of pacemaker, uncalibrated spectrophotometer) or indicate if cause is unknown
4. Name of manufacturer, model number and serial number of the device, if possible
5. What action, if any, was taken to correct the problem or prevent future injuries (e.g., replaced with new equipment, rewired electric cord and plug, unknown)

The more details you can provide, the more valuable your contribution will be. A standard short reporting form is available on request.

Write: *Health Devices Hazard Reporting System*, The Emergency Care Research Institute, 913 Walnut Street, Philadelphia, Pa. 19107; or telephone: (215) 923-5470.

## New Associate Dean Named

Dr. James E. Carter, associate professor of obstetrics and gynecology at the Indiana University School of Medicine, has been appointed associate dean for student affairs at the school.

He succeeds Dr. Edward A. Tyler, professor of psychiatry, as head of the school's student affairs programs.



"Read me that part about you again, Dad."



## Additional Copies Available of "Set Your Affairs in Order"

THE JOURNAL is pleased to announce that it has a supply of additional copies of the eight-page leaflet titled "Set Your Affairs in Order," which was inserted in the June issue.

Intended to make it convenient for physicians to record vital information concerning their practice, business, legal, insurance and financial affairs, the leaflet was also designed to encourage physicians to record in one place all the data necessary for rapid decisions in case of serious illness or death.

Requests for copies of the leaflet will be filled as long as the supply lasts.

## Two Faculty Appointments For Evansville Center Made

Dr. Edward J. Gesser, a native of Evansville, has been appointed assistant professor of anatomy. Dr. Gesser, who received a bachelor of science degree from Western Kentucky University and a doctor of philosophy degree from the University of Louisville, has been associate professor of anatomy at Texas College of Osteopathic Medicine.

Dr. Gordon J. Deitch, a native of Pakistan, has been appointed associate professor of physiology. Dr. Deitch holds degrees from the University of Alberta (Canada), Ohio State University, and the University of Chicago. He has been a visiting professor on the special overseas staff of the Rockefeller Foundation for the last five years.

## Offer Microshock Hazards Leaflet

A new newsletter that examines today's critical problem of microshock hazards associated with medical/electronic instrumentation is published by Welex Electronics, a Halliburton Company. The brochure, called ISODATA, discusses medical electronic safety, and, in detail, how microshock may be greatly reduced with the proper electronic equipment designed specifically for the medical world. For copies of ISODATA write Welex Electronics, P.O. Box 986, 2431 Linden Lane, Silver Springs, Md. 20910.

## Dr. Paul Martin Honored

**Dr. Paul H. Martin** was recently honored at a banquet on the occasion of his retirement as Commissioner of Health of Elkhart County. Dr. Martin is well known for his intensive effort to identify phenylketonuria in newborns. In 10 years over 25,000 newborns were tested by a home testing product manufactured by the Ames Company. A particular religious group in Elkhart County was found, by this process, to have an especially high incidence of PKU. Usually the disease occurs once in 10,000 newborns. Thirty five cases were found in Elkhart County.

## Dr. Van Hove Certified

**Dr. Eugene D. Van Hove**, Indianapolis, has recently passed the certifying examination in Nuclear Medicine. The American Board of Nuclear Medicine was formed recently as a conjoint board of the American Board of Internal Medicine, Pathology, and Radiology.

## Dr. Jack Clark Aids in Rapid City Disaster

**Dr. Jack Clark**, Syracuse, was attending a four-day medical meeting on "Death and Dying" at Rapid City, S.D., when the nation's worst flood in 35 years occurred in the area.

Separated by the flood waters from the hospital, which was across town from the meeting site, the physicians set up a first aid station in one of the motels.

Dr. Clark rode for some of the first hours of the disaster in a police car, administering first aid. When the water receded sufficiently to reach the hospital, he assisted in the efforts there.

## Heart Valve Study Funded

The Indiana Heart Association has provided two financial grants to the University of Notre Dame for a basic engineering study of prosthetic heart valves. Dr. Thomas J. Mueller will study "Hemolytic Potential of Prosthetic Heart Valve Flow." Dr. John R. Lloyd will be concerned with "Design and Evaluation of a New Leaflet Heart Valve."

## Marion General Names Medical Staff Officers

The medical staff of Marion General Hospital has announced the names of new officers and committee chairmen for 1972-73.

Dr. Max P. Long was named president, and Dr. R. Lee Walton, vice president. Dr. James D. Reid will continue as secretary of the staff.

Other members of the executive committee will include Dr. Fred R. Malott, chief of medicine; Dr. Don E. Rhamy, chief of surgery; Dr. John C. Jarrett, chief of obstetrics, and Dr. Doris A. Jesch, chief of pediatrics.

Standing committee chairmen are Dr. R. M. Hummel, credentials; Dr. R. E. Lahr, medical records, and Dr. J. P. Powell, tissue committee.

Special committee chairmen appointed for the coming year are Dr. L. K. Musselman, accreditation; Dr. Charles F. Abell, building; Dr. H. H. Alderfer, coronary care unit; Dr. R. M. Brown, dietary; Dr. J. L. Fuelling, disaster planning; Dr. E. E. Smith, medical education, and Dr. H. D. Khalouf, emergency room.

Other special committee chairmen are Dr. R. D. Chaney, intensive care unit; Dr. Jesch, nursery; Dr. F. E. Dunbar, pharmacy and advisor to the nursing arts; Dr. L. D. Wojcik, poison control; Dr. S. T. Khalouf, physical therapy; Dr. M. Percy, research and development, and Dr. J. A. Tomlinson, infection, library and transfusion.

**DR. B. L. MARTZ**, who has been director of the Lilly Laboratory for Clinical Research since 1960, has been named to the faculty of the School of Medicine of the University of Missouri-Kansas City, according to an announcement by Dr. E. Grey Dimond, UMKC provost of health sciences.





## Receives Golden Apple Award

**Dr. Howard Engel, South Bend,** was the recipient of this year's Golden Apple Award from the house staff at St. Joseph's Hospital. **Dr. Thomas Troeger,** director of the South Bend Center for Medical Education, made the presentation. The house staff doctors give the award annually to the physician who, they think, has contributed most to their medical education.

## What's New?

**THE** new Overly/Bressler Stand Up Wheel Chair is the first such device which permits users to stand whenever they wish. The standing position is not only convenient for a patient who works, but also contributes to better bodily functions and improved calcium metabolism. To stand up, the user swings the foot rests down to the floor, then releases a set of knobs protruding from the seat rails and leans forward. This frees automatic locks and permits concealed spring pistons, adjusted to the user's weight, to gently lift the individual into any desired position up to 10 degrees from vertical.



## Dr. Hodel on Methodist Staff

Harry L. Hodel, M.D., has become a member of the Department of Radiology of the Indianapolis Methodist Hospital. He will specialize in uro-radiology and angiography.

## IRMP Receives Additional Funds

The Indiana Regional Medical Program has received an additional award of \$260,046 which will be used for new health care projects and also to assist in expanding some established programs. The new projects that will be assisted include (1) A Health Hazard Appraisal Project which is a cooperative venture in prospective medicine between Methodist Hospital in Indianapolis and other hospitals and physicians in the state; (2) A Radiation Therapy Development and Physics Support Project to provide services in radiation therapy in hospitals over the state; (3) A special information and motivation project to improve supply of health manpower in Indiana; (4) A project to provide proper matching of kidney donors and recipients; and (5) An evaluation of a new Family Nurse Practitioner Program to train registered nurses to perform, under physician supervision, functions formerly done only by physicians in the practice of family medicine.

## Fire Protection Booklet Offered

"Nursing Home Fires and Their Cures" is a 40-page booklet published by the National Fire Protection Association to increase awareness of fire hazards and advise as to prevention. Recommended for nursing home supervisors and staff members, for architects, fire marshals, fire inspectors and fire prevention officers. The cost is \$2.50. Address the Association at 60 Batterymarch St., Boston 02110.

## Stryker Co. Offers New Movie

The Stryker Corporation has a new movie to document the need for the use of the Stryker CircOlectric Bed and to demonstrate its use. The title of the movie is "Danger! Im-mobility!" For complete information write Mr. Robert Beard-sley, 420 Alcott St., Kalamazoo, Mich. 49001.

## Named "Nurse of the Year"

Miss Anne L. Gibbs, Executive Director of the Visiting Nurse Association of Indianapolis, has received the 1972 Nurse of the Year Award from the Indiana League for Nursing and the Allstate Foundation. The award recognizes Miss Gibbs' dedicated service to the community as well as her contributions on state and national levels.

## IUSM Names 11 to Faculty

Dr. Glenn W. Irwin Jr., dean of the Indiana University School of Medicine, has announced the appointments of 11 full-time members of the faculty. They are:

Dr. Donald R. Hawes, assistant professor of radiology. Dr. Hawes, a native of Fort Wayne, received his undergraduate and medical degrees from Indiana University and served his residency in the Indiana University Hospitals.

Dr. John A. Robb, associate professor of radiology. Dr. Robb, a native of Billings, Mont., received an undergraduate degree from the University of Nebraska and his medical de-



gree from the University of Nebraska College of Medicine. He has been in private practice since 1946.

Dr. Stanislav M. Gajisin, assistant professor of anatomy. Dr. Gajisin, a native of Yugoslavia, received his medical degree from the Universitet u Novum Sadu Medicinski Fakultet in 1967 and has been an instructor in anatomy at the University of Chicago.

Dr. Stephen D. Roberts, associate professor of community health sciences. Dr. Roberts, a native of Warsaw, received bachelor's master's, and doctor's degrees from Purdue University. He has been director of Health Systems Research Division at the University of Florida.

Dr. Horton A. Johnson, professor of pathology. Dr. Johnson, a native of Cheyenne, Wyo., received an undergraduate degree from Colorado College and his medical degree from Columbia University. He has been professor of pathology at the State University of New York.

Dr. Sheldon M. Epstein, associate professor of pathology. Dr. Epstein, a native of Brooklyn, received an undergraduate degree from Brooklyn College, a doctor of osteopathy degree from Des Moines Still College of Osteopathy and Surgery, and a medical degree from the California College of Medicine. He has been associate professor of pathology at the University of Pittsburgh Medical School.

#### Pediatricians Named

Dr. Sterling D. Garrard, professor of pediatrics. Dr. Garrard, a native of Chicago, received an undergraduate degree from the University of Illinois and a medical degree from the University of Illinois College of Medicine. He has been professor of pediatrics at the State University of New York Upstate Medical Center.

Dr. Mary Ellen Babcock, assistant professor of pediatrics. Dr. Babcock, a native of Hammond, received an undergraduate degree from Marian College and her medical degree from the Indiana University School of Medicine. She has been a post-graduate fellow in child development at the I.U. Medical Center.

Dr. Arnold J. Altman, assistant professor of pediatrics. Dr. Altman, a native of Baltimore, received an undergraduate degree from Johns Hopkins University and his medical degree from the Johns Hopkins School of Medicine. He has been a hematology fellow at Children's Hospital Medical Center.

Dr. Chi Yol Ryu, assistant professor of radiology. Dr. Ryu, a native of Korea, received his medical degree from the Medical College of Seoul National University. He has been assistant professor of radiology at Vanderbilt University Hospital.

Dr. Mutaz Billah Habal, assistant professor of surgery. Dr. Habal, a native of Syria, received his medical degree from American University of Beirut Medical School. He has been a student, intern, resident and fellow at Harvard Medical School.

#### Bill Introduced Strengthens FDA

One of the most important pieces of legislation affecting the Food and Drug Administration in ten years (H.R. 15315) was

introduced last month and referred to the House Commerce Committee. The work of Congressman Paul Rogers' Health Subcommittee, the measure and an earlier bill (H.R. 15003) introduced by Congressman Moss both differ fundamentally in purpose from the Magnuson bill (S. 3419) recently passed by the Senate. Whereas the Moss and Rogers approach would structure a stronger FDA within HEW, Magnuson's bill would dismantle it, and place it under a new consumer safety agency.

Many observers have expressed concern that the Magnuson approach, though enjoying the support of various "consumer" advocates, would have the net effect of producing a regulatory vacuum that might last for months or years while the new agency was being formed. Moreover, the notion that the new agency would somehow be more "independent" than HEW has been categorized as extremely naive by informed Washingtonians.

Some House action on the Moss bill is likely this session, and action is possible or probable on the Rogers bill. The ultimate administrative fate of FDA, therefore, depends upon whatever bill clears the House and on what happens to the Senate and House versions in conference.

—National Pharmaceutical News.

#### Dr. Hedrick Pediatric Fellow

Dr. Phillip William Hedrick, Indianapolis, has been elected to Fellowship in the American Academy of Pediatrics.



*"Your dinner was perfect—from soup to 'Dicarbosil'."*

**Dicarbosil®**  
ANTACID  
*Write for Clinical Samples*  
**ARCH LABORATORIES**  
319 South Fourth Street, St. Louis, Missouri 63102



# Whats New?

Doubleday has just published "Why Natural Child-birth?" by Dr. Deborah Tanzer. Material for the book was obtained by interviewing and testing two groups of women—those who had delivered babies by the conventional method with anesthesia and those who had been prepared beforehand and had delivered without anesthesia. 312 pages—price \$7.95.

\* \* \*

Upjohn has a "best seller" in the form of a medical movie "Hypnosis as Sole Anesthesia for Cesarean Section" which has been viewed by more than a quarter of a million persons. It is one of the award-winning Upjohn Vanguard of Medicine® series.

\* \* \*

Dixon Medical Products has a new special medical grade Teflon or Polyethylene tubing which features guaranteed angular rotation and radiopacity. It is non-toxic and non-reactive to tissue. It is available in translucent and radiopaque, in heavy and thin wall and in complete size range from French #2 to #14.

\* \* \*

Squibb announces that Sumycin HC1 is now available in 250 mg and 500 mg tablets. The tablets have a coating which eliminates bitter taste. The coating also becomes slippery when moist. This, plus the small size of the new tablets, makes swallowing easier for patients who have difficulty with large tablets.

Labconco is introducing a Fume Hood Fire Extinguisher which provides automatic spot fire protection. It can be mounted in a fume hood or in any other location with a fire hazard. When triggered by a temperature of 255 F it releases a non-toxic fire repellant, a dry chemical powder which, in combination with liquids, forms a soap solution. It is rechargeable and has a visual pressure gauge for visual inspection.

\* \* \*

Manley Management and Marketing Services forecasts that health care will be the world's largest industry by 1975 and that diagnostic equipment sales will reach \$384 million by then. The first of a three-volume series of reports has just been published. It presents product information, product markets and a list of major manufacturers in the field. Over 270 companies are listed.

\* \* \*

Bunting Sterisystems announces a new system called SteriCenter which is an electronic push-button nurses' center which provides instant audio and visual communication with every hospital patient, as well as nurses, nurses' aides and other personnel. It may be operated by one nurse and will provide two-way communication with patients and all members of the staff. The nurse's picture appears on the patient's screen and vice versa.

\* \* \*

Bell and Howell is introducing a new precision super 8 movie camera called the Canon® Auto Zoom 814 Electronic. It replaces the regular Canon 814. It offers many improvements in adjustable controls and automatic features.

\* \* \*

Vikton makes cubicle drapes from olefin and nylon mesh which sell for less than the cost of laundering standard jean cloth curtains. The mesh border permits circulation of air and light. The bright white surface and the green border add to the decor. The material is fire retardant. Its cost is low enough to enable its complete disposal after use with an infectious or contagious case.

\* \* \*

Sage Products has a new midstream urine collection kit which protects the specimen from contamination during its transfer from the patient to the container and to the laboratory. Necessary instructions for collection and a supply of towelettes for pre-delivery preparation, funnel, container, cap and label are all packaged in one kit.

\* \* \*

Technicon Corporation announces a Laboratory Management Services Division which will furnish teams of consultants—pathologist, laboratory manager and management engineer—to advise on the organization and management problems of laboratories. Technicon points out that the modern laboratory director must be an administrator, budget director, accountant, architect, personnel manager, purchasing agent, technical supervisor, and also find time to be a pathologist. Technicon services will be of two types: one-time on-site survey visits and evaluations, or on-going consultation services arranged on an annual basis.



"The electric eye on my garage door didn't work and I drove right through it."



# Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

## For more modern anemia therapy

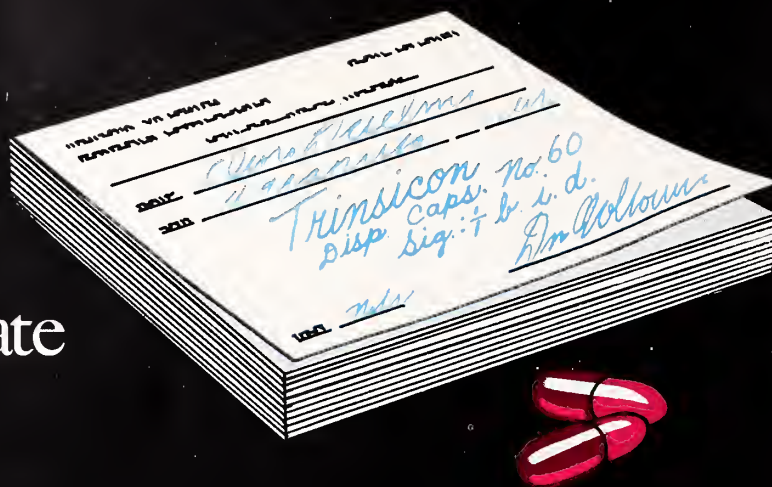
**Trinsicon<sup>®</sup>**  
Hematinic Concentrate  
with Intrinsic Factor

(See reverse side for prescribing information.)



# Trinsicon®

## Hematinic Concentrate with Intrinsic Factor



**Description:** Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly  
(containing Intrinsic Factor) . . . . . 240 mg.  
Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 7.5 mcg.  
(The total vitamin B<sub>12</sub> activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Iron, Elemental (as Ferrous Fumarate) . . . . . 110 mg.  
Ascorbic Acid (Vitamin C) . . . . . 75 mg.  
Folic Acid . . . . . 0.5 mg.

**Indications:** Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

**Vitamin B<sub>12</sub> with Intrinsic Factor**—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B<sub>12</sub> in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B<sub>12</sub> leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B<sub>12</sub>. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B<sub>12</sub> deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B<sub>12</sub> contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B<sub>12</sub>) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

**Folic Acid**—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B<sub>12</sub> deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B<sub>12</sub> interrelationship: (1) B<sub>12</sub> influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B<sub>12</sub> progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B<sub>12</sub>.

**Iron**—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

**Ascorbic Acid**—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

**Contraindications and Precautions:** Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B<sub>12</sub>-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B<sub>12</sub> may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B<sub>12</sub>. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

**Adverse Reactions:** In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

**Dosage:** One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

**How Supplied:** Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500 and in Ident-Dose® (unit dose medication, Lilly) in boxes of 100.

[090971]

## Trinsicon®

### Hematinic Concentrate with Intrinsic Factor

### A Comprehensive Hematinic

*Additional information available to the profession on request.*

Eli Lilly and Company  
Indianapolis, Indiana 46206

*Lilly*

201378



# *New Members, Additions to ISMA Roster*

*The Journal* welcomes the following physicians who have become members of the Indiana State Medical Association since the publication of the Roster of Members in the June issue:

## DUBOIS

Daniel C. Drew, M.D.  
Jasper Medical Arts Building  
Jasper 47546

## ALLEN COUNTY

James S. Hill, M.D.  
2902 Fairfield Ave.  
Fort Wayne 46807

Sung Soo Kim, M.D.  
3010 East State Blvd.  
Fort Wayne 46805

## HENDRICKS COUNTY

Ursula E. Mitman, M.D.  
R.R. 2 Box 322  
Plainfield 46168

## LAKE COUNTY

Rodolfo M. Almase, M.D.  
904 West Ridge Road  
Hobart 46342

Sang Ho Han, M.D.  
7550 Hohman  
Munster 46321

Manuel Ricardo Luna, M.D.  
110 Ridge Road  
Munster 46321

J. Matthew Neal, M.D.  
7905 Calumet  
Munster 46321

## LA PORTE COUNTY

Robert E. McBride, M.D.  
1701 Buffalo  
Michigan City 46360

## LAWRENCE COUNTY

E. D. Luddington Bennett, M.D.  
Dunn Memorial Hospital  
Bedford 47421

## MONTGOMERY COUNTY

Jose Peralta, M.D.  
411 Tinsley Ave.  
Crawfordsville 47933

## RIPLEY COUNTY

A. A. Daftary, M.D.  
413 North Elm St.  
Batesville 47006

## ST. JOSEPH

Edward A. Gergesha, M.D.  
211 North Eddy St.  
South Bend 46617

David F. Wehlage, M.D.  
120 West LaSalle W. Bldg.  
South Bend 46601

## TIPPECANOE COUNTY

Lorand S. Becsey, M.D.  
405 Life Building  
Lafayette 47901

## VANDEBURGH COUNTY

Tony E. Hood, M.D.  
600 Mary St.  
Deaconess Hospital  
Evansville 47710

## VIGO COUNTY

Gerald P. Johnston, M.D.  
Katherine Hamilton Mental Health  
Center  
Terre Haute 47807

## *INDIANA MEDICAL BUREAU*

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Indianapolis, Indiana 46208  
925-9008*

*A Licensed Employment Agency  
Specializing in Medical Personnel*

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# *The Woman's Auxiliary*

## REPORTS TO ISMA

The mid-summer board meeting of the WA-ISMA was held July 18 in Indianapolis. The board heard reports from the state chairmen to bring us up to date on the affairs of the auxiliary.



An orientation program for the nursing home visitation project in Clarksville on July 10 attracted a number of auxiliaries. A team from the State Board of Health, headed by Dr. David J. Edwards, presented a one-day program to acquaint the ladies with all aspects of visiting a nursing home.

The state AMA-ERF chairman, Mrs. Claude Meyers, announced that the Indiana Auxiliary raised \$21,151.21 for AMA-ERF through the sale of jewelry and Christmas cards, and by memorials and direct gifts. This represents the largest amount ever presented to AMA-ERF by the Indiana Auxiliary and follows the national trend.

The legislative committee is hard at work already to prepare programs for presentation before election day. Between now and November 7, 1972, the hope is to rally auxiliary members to get busy in support of the presidential candidate of their choice. The legislators, governors or local candidates who have proven to be, "friends of medicine" and the presidential candidate whose program gives medicine its best chance are worthy of support. This must be our guideline for choice in the coming campaign and we must work to earn the right to our freedom by having a 100% vote by doctors and their families.

LEGS is the new vehicle to do the work the AMA is asking auxiliary members to do. LEGS—Legislative Effort Group System. LEGS are needed to carry the load of legislation and politics to our members, our doctor-husbands, to our congressmen, to our senators. Our LEGS are really auxiliary members who will fulfill the responsibility of being good citizens for themselves and for the medical profession.

We also heard the proposed schedule of women's activities at the ISMA state convention October 15-18. The annual art and hobby show will be available for viewing Monday, Oct. 16 and Tuesday, Oct. 17, from 8:30-4:30 and on Wednesday, Oct. 18 from 8:30-12:30.

A guided tour of the city is planned for Monday afternoon from 1:00-4:00. This will include the ladies and their husbands. Tuesday morning the opening board meeting of the Woman's Auxiliary to the ISMA will be held at 10 o'clock at the Convention Center. All ladies are invited to attend.

Everyone is urged to attend the general meeting on Tuesday afternoon covering the subject of "Health Care Delivery in the U. S."

Wednesday morning, coffee at the Morris Butler home will be followed by a walking tour of Broadripple Village Shops, if so desired.

This promises to be an informative and entertaining state convention! We hope you all will plan to come join us.

Following the presentation of these reports, the board meeting was adjourned. See you in Indianapolis in October.

*Marjorie Smith*



## WANTED: Physicians Locations

### ALLERGY

Tokrisna, Aphiraks, 5901 E. 7th St.,  
Long Beach, Calif. 90801

### FAMILY PRACTICE

Judson, Preston L., Presbyterian Hosp.,  
Pacific Medical Center, Clay & Web-  
ster St., San Francisco, Calif.

### GENERAL SURGERY

Ahmad, Manzoor, 1540 Garden Terr.  
#511, Charlotte, N.C. 28203

Choi, San Ho, 4623 Orchard Dale N.W.,  
Canton, Ohio 44709

Fox, Gerald E., 3126 Harvard Rd., Royal  
Oak, Mich. 48072

Lebenson, Ira M., 350 E. 30th St., New  
York, N.Y. 10016

Obregon, Pedro J., 2513 Jackson Ave.,  
Pt. Pleasant, W. Va. 25550

Padanilam, George J., 813 Walbridge,  
Toledo, Ohio 43609

Rajasekharan, S., 18717 James Couzens,  
#101-E, Detroit, Mich. 48235

### INTERNAL MEDICINE

Dahhan, Abdulkader, Stevens Clinic,  
Welch, W. Va. 24801

Darab, Manoochehr, 5030 N. Marine  
Dr., Chicago, Ill. 60640

Hag, Azhar-ul, 120 Meyer Rd., Apt. 127,  
Amherst, N.Y. 14226

Huff, Harry, 1938A Williford, Ft. Eustis,  
Va. 23604

Kane, Peter J., 8021 28th Ave., N.E.,  
Seattle, Wash. 98115 (Hematology-  
Oncology)

Mohindra, Beldev K., 35 Charles St. W.,  
Toronto, Ontario, Canada

Mehrotra, Badri N., 3901 Ireland Dr.,  
Cleveland, Ohio 44122

Rana, Shamsuddin, c/o V.A. Hosp., Uni-  
versity Dr., Pittsburgh, Pa. 15240

Regis, Bill, 4912 North St., Louis Ave.,  
Chicago, Ill. 60625

Waddell, William R., R.R. #3, Bath, On-  
tario, Canada

### OBSTETRICS & GYNECOLOGY

Ari, A. Necip, Mithat Pasa 21-4, Ankara,  
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### OPHTHALMOLOGY

Lantz, John M., 5285 Kent St., Apt. 12,  
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### ORTHOPEDICS

Raja, Desingu S., 2701 S. Indiana Ave.,  
Apt. 408, Chicago, Ill. 60616

Shroyer, Russell N., 1575 W. Celeste,  
Fresno, Calif. 93705 (I.U. Grad.)

### NEUROSURGERY

Fruin, Alan H., 2506 Ashwood, Nash-  
ville, Tenn. 37212

### PEDIATRICS

Kelley, Kenneth H., 1515 Circle Dr.,  
Burnsville, Minn. 55337

Aftab, Ahmad Aftab, 3630-Rue Foret,  
A-154, Flint, Mich. 48504

Myers, Delbert D., 5600 Chimmney  
Rock, Apt. 11, Houston, Tex. 77036

### PATHOLOGY

Hernandez, Eugenio, 1215 W. Empire,  
#12, Freeport, Ill. 61032

Malik, Muhammad I., Dept. of Path.,  
I.U.S.M., 1100 W. Mich., Indianapolis,  
Ind. 46202

### UROLOGY

Salcedo, Alfredo L., 205 W. 20th St.,  
Lorain, Ohio 44052

### OTHER

MEDICAL DIRECTOR — PROVEN  
QUALITY, COST EFFECTIVE MEDI-  
CAL-COMPUTER APPLICATIONS  
AND SEMI-AUTOMATION

Heinmiller, E. Clifford, 1124 Washburn  
Pl. W., Saginaw, Mich. 48602

### PHYSICAL MEDICINE & REHABILITATION

Safman, Bruce L., 1032 W. Vine St.,  
Springfield, Ill. 62704

## ABOUT OUR COVER

This month's cover features the "Monumental Stairway" in the main hall of the new Convention-Exposition Center at Indianapolis where the 123rd annual meeting of the Indiana State Medical Association will be held.

We are indebted to the management of the Convention-Exposition Center for the use of this drawing which was given to them by the Indiana Bell Telephone Company.



# Association News

## BOARD OF TRUSTEES

June 10, 1972

The Board of Trustees convened at 6:30 p.m. Saturday, June 10, 1972, with the AMA delegates and Dr. Joe Dukes, chairman, calling the meeting to order.

Roll call showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Jack Shields	Present
5	Wilbert McIntosh	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
	Dwight Schuster	Present
8	Richard Ingram	Present
9	Wm. Sholty	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Absent
12	Wm. R. Clark	Present
13	G. Beach Gattman	Present

Alternate	Trustee	
1	Raymond Newnum	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Absent
4	Howard Jackson	Present
5	C. M. Schauwecker	Present
6	Glen Ward Lee	Present
7	Joseph F. Ferrara	Present
	Joseph Kerlin	Absent
8	Jack Alexander	Absent
9	Max N. Hoffman	Absent
10	Thomas Tyrrell	Present
11	James Harshman	Present
12	Walter D. Griest	Absent
13	Donald Chamberlain	Present

Trustees-elect		
2	Paul W. Holtzman	Present
4	Howard C. Jackson	Present
5	C. M. Schauwecker	Present

Alternate	Trustees-elect	
4	Wm. F. Blaisdell	Present
5	Wm. G. Bannon	Present
10	Martin J. O'Neill	Absent

Officers:		
Peter R. Petrich	Present	
James H. Gosman	Present	
Lester H. Hoyt	Present	
Hugh K. Thatcher	Present	
Frank B. Ramsey	Absent	

Executive Committee:		
Donald M. Kerr	Present	
Wilbert McIntosh	Present	

## AMA Delegates and Alternate Delegates:

James Harshmann	Present
Eugene Senseny	Present
Frank Green	Present
Jack Shields	Present
Lowell H. Steen	Present
A. Alan Fischer	Present
Eugene Rifner	Absent
Kenneth O. Neumann	Present
P. J. V. Corcoran	Absent
Thomas Tyrrell	Present
Sprague Gardiner	Present
Myron Nourse	Absent
Lall G. Montgomery	Present

## Guests:

Donald E. Wood, M.D.,	
AMA Trustee	Absent
Guy Owsley, M.D., Chairman,	
Council on Medical Services	Present
Malcolm O. Schamahorn, M.D.,	
Immediate Past President	Present
Arthur G. Loftin,	
Secretary Marion County	
Medical Society	Present

## Staff:

Robert Amick	Present
Howard Grindstaff	Present
John Walters	Present
Kenneth Bush	Present
Jas. A. Waggener	Present

The meeting opened with the delegates reviewing the matters to come before the AMA House of Delegates at the San Francisco meeting. Following his review, Dr. Senseny proposed a resolution to be presented by the Indiana delegation at the meeting. After a discussion, upon motion of Dr. Shields, it was voted that such a resolution would not be introduced by the Indiana delegation.

A letter was read from Dr. Walter C. Bornemier asking the support of the Indiana State Medical Association on a declaration of intent statement. Following discussion, upon motion of Dr. Gosman and seconded by several, it was voted that the Indiana State Medical Association would not add their name to this document.

A resolution suggested by Dr. Wood for introduction at the AMA meeting in San Francisco was presented and discussed. Upon motion of Dr. Shields, seconded by Dr. Clark, it was voted that Indiana would not present such a resolution at the AMA meeting.

Resolution 18 contained in the Delegates Handbook was then discussed and, on motion of Dr. Petrich and seconded

by Dr. Gosman, it was voted that the Indiana delegation would oppose this resolution.

The report of the Board of Trustees was then discussed concerning the separation of the scientific meetings from the House of Delegates meeting of the AMA and, following discussion on this matter, on motion of Dr. Petrich and a second by Dr. Santare, the delegates were to go uncommitted on this particular issue.

The schedule of meetings for the AMA session was then reviewed by Dr. Petrich, president.

There being no further business, the meeting was adjourned, to meet again at 8:30 a.m. June 11, 1972.

June 11, 1972

## BOARD OF TRUSTEES

The Board of Trustees of the Indiana State Medical Association convened at 8:30 a.m. Sunday, June 11, in the Headquarters Building.

Roll call showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Jack Shields	Present
5	Wilbert McIntosh	Absent
6	Paul M. Inlow	Absent
7	John O. Butler	Absent
	Dwight Schuster	Present
8	Richard Ingram	Present
9	Wm. M. Sholty	Present
10	Vincent J. Santare	Present
11	Lowell Hillis	Absent
12	Wm. R. Clark	Present
13	G. Beach Gattman	Present

District	Alternate	
1	Raymond Newnum	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Absent
4	Howard Jackson	Present
5	C. M. Schauwecker	Present
6	Glen Ward Lee	Present
7	Joseph F. Ferrara	Present
	Joseph Kerlin	Absent
8	Jack Alexander	Absent
9	Max N. Hoffman	Absent
10	Thomas Tyrrell	Present
11	James A. Harshman	Present
12	Walter D. Griest	Absent
13	Donald Chamberlain	Present

Trustees-elect		
2	Paul W. Holtzman	Present
4	Howard C. Jackson	Present
5	C. M. Schauwecker	Present



**Alternate Trustees-elect**

4 Wm. F. Blaisdell	Present
5 Wm. G. Bannon	Present
10 Martin J. O'Neill	Absent

**Officers:**

Peter R. Petrich	Present
James H. Gosman	Present
Lester H. Hoyt	Present
Hugh K. Thatcher, Jr.	Present
Frank B. Ramsey	Present

**Executive Committee:**

Donald M. Kerr	Present
Wilbert McIntosh	Absent

**Guests:**

Andrew C. Offutt	Present
Glenn W. Irwin, Jr.	Absent
Joe M. Black	Present
Arvine Popplewell	Present
Fred Dahling	Present

**Staff:**

Robert Amick	Present
John Walters	Present
Jas. A. Waggener	Present
Howard Grindstaff	Present
Kenneth W. Bush	Present

MINUTES OF THE MEETING HELD MARCH 5, 1972 were approved on motion of Drs. Petrich and Gosman.

DOCTOR GOSMAN reviewed his previous comments concerning the association writing a letter endorsing the Pediatric Nurse Training Program at the Methodist Hospital and moved that the association transmit such a letter of endorsement.

The motion was seconded by Dr. Wilhelmus and carried.

DOCTOR PETRICH: President Petrich reported to the Board that his travels had been extensive throughout the state and he had talked to many members pointing out that he did not believe the association activities were very far out of line with what the physicians are thinking.

Doctor Petrich pointed out that later in the day he would have some reports from the commissions and committees and stated that he, along with the president-elect, the chairman of the Board, and the executive secretary met with the chairmen of these various commissions and committees, at which time reports were made by each chairman of their accomplishments and their plans for the rest of the year.

PRESIDENT-ELECT GOSMAN: I would like to reiterate some of the things that Doctor Petrich has commented on, as I have found in getting

around to the various districts there seems to be a tremendous interest in the programs the association has supplied with discussions on Peer Review; HMOs and Foundations. The biggest gripe I find continues to be our relationship with Blue Shield. It is my opinion that we must absolutely solve and ease these problems.

Dr. Gosman pointed out he would soon be calling on members to serve on the various commissions and committees of the association and complimented the president for his stimulation of these groups during his year.

DR. GOSMAN: I would like to impress upon you there is some important information which should be brought to the House of Delegates from these commissions and committees and I would urge each of you to read the reports carefully.

I have sought permission from the Board to have Doctor Popplewell here, which I will do later, to report on what is happening in Indianapolis as far as the HMO program is concerned. I do wish to let you know that at a meeting of the Council of the Methodist Hospital it was stated they were looking into and investigating the HMO concept as far as the hospital is concerned. They figure that, with their employees and families, they would have a group of 10,000 in their organization, but did not say they were going to do it.

I would like the approval of the Board on the following matter—in my relationship with the Continuing Medical Educational Program and the Indiana Plan for externships, internships, residencies and Physicians' Continuing Educational Program, there is a question of finances. We have come up with the idea that we need a line item to present to the legislative body for monies to finance the program rather than put the burden on the hospitals and, ultimately, the patient. We have discussed this with both candidates for the governorship so that they will be informed well in advance of what we may attempt to do. I can report they both were pleased with the idea.

The idea which I would like approved is that the Indiana State Medical Association, the Indiana University School of Medicine, Indiana Hospital Association, and the Indiana Medical Educators will band together to use our influence on legislative actions in forthcoming session. Therefore, I now move for the approval of the Indiana State Medical Association to join with the School of Medicine, Indiana Hospital Association and Indi-

ana Medical Educators in backing this type of legislation.

The motion was seconded by Dr. Clark and discussed by Drs. Wilhelmus, Dr. Gosman, Dr. Thatcher. The motion was put to vote and carried.

TREASURER'S REPORT: Dr. Lester Hoyt, Treasurer, reviewed in detail the financial report of the association as of May 31 and moved its acceptance. The motion was seconded by Dr. Harshman, put to vote and carried.

DR. GOSMAN: I would like to move that a sum of money in the building fund be specifically earmarked for addition or construction of additional facilities to our building and that this action be made a matter of record.

The motion was seconded by Dr. Goodman, discussed by Dr. Thatcher, put to vote, and carried.

**REMARKS OF DR. OFFUTT:**

Mr. Chairman and members of the Board, I am appearing in two hats today as I will be with Dr. Johnson when he discusses the report of the Commission on Public Health but prior to that there are a couple of things that I would like to mention.

First—I have reasonable knowledge that a Certificate of Need bill once again will be entered in the forthcoming session of the state legislature. I do not know whether the Board knows it or not but Representative Bales is having regular meetings of the Task Force on Public Health. It is important, in my opinion, that the ISMA be represented at these meetings as things are being discussed which may be of strict importance to the medical profession.

Two—we have amended the basic Anatomical Gift Act in accord with the legislative requirement. We have adopted and are processing regulations concerning the distribution of blood and blood derivatives, which translates into regulations for blood banks.

The other thing that has caused some problems is the amendment to the Health Facility Regulation. This is an amendment to allow licensed nursing homes and will apply only to comprehensive licensed homes which are skilled nursing homes, the residential care facilities, to set apart a specific area in their home as an intermediate care facility. The Department of Public Welfare has been told that in the intermediate care facilities they can only pay for one and one-half to two hours of care and that is an average of one and a half to two hours of care in the skilled facili-



ties or, as we license them in Indiana, the comprehensive care they can still pay for two and a half. They used to pay for two and a half to three and they now pay for two and a half and these are average amounts of time. Now what has happened has been or was obviously a blow to the six, eight, ten, twelve, fourteen-bed homes. One of the things that has been extremely difficult to understand is why this made a problem in providing nursing care. The place where you will get into the act is when you put anybody into an intermediate care facility. If they are paying themselves or if they have an insurance company third party payee, it makes no difference who the payor is. The standards are set by the Department of Public Welfare under Medicaid. Regardless of who pays the bill, the patient will still get what the Department of Public Welfare is getting for their people.

When the Health Facilities Licensing Council meets I will present to them a proposition which has been made in calculating nursing care in nursing homes. There will be included several other types of care the patients need. For example, in many of the larger homes they have people that come in at noon whom they call "the feeders." And the nursing home administrators say this is necessary and therefore they would like to count the time that these people work as time consumed for nursing care. Another factor which is going to create tremendous problems is that the physical therapist or anybody who is called into a nursing home on a part time or a full time basis will be charged against nursing care. Now this will make it very easy for any home to reach the one and a half hour average for intermediate care and two and a half for the comprehensive or skilled care. I will be glad to answer any questions and, Mr. Chairman, this constitutes my report from the Board of Health.

**DR. HARSHMAN:** We have been having some discussion on the proposed 5% charity work for hospitals who have accepted Hill-Burton funds. We would be interested in knowing what the current status is.

**DR. OFFUTT:** I have a very definite stand on this which is public knowledge as far as Washington and the Department of Health, Education, and Welfare is concerned. It is a bad deal. We have been asked to come up with a substitute and the substitute I would like to come up with is nothing. I fought this battle with OEO a year ago with their attorney. They came and talked to me and

wanted to know what I was going to do about the hospitals in Indianapolis that were not giving their full measure of free care. In Indiana I do not know who gets free care—somebody pays for it. It either falls into the classification of welfare, Medicaid, Medicare or the trustee or it is a bad debt. Of course all of these are excluded from the regulations. I think the regulation is illegal. I am not an attorney but the law says that an applicant for Hill-Burton funds shall give assurance to the state agency—that's us—that they will render a reasonable volume of free medical care. The lawyers now have gotten down to the nitty gritty of this in a hurry and they decided that perhaps they had not studied the law adequately and they went away and I have not seen them since. What I have quoted to you is about as accurate as I can recall it and my attitude has been this way for 18 years that when you sign a payment application saying that you will give this kind of care then that means you are going to give it. In 18 years we have had no complaints either that anybody in Indiana has been turned away. Now this may not be true in other states but I am only restraining myself pointing out to you in some detail just what I have talked to you about since 1954 that these people who sit in Washington and who regulate these problems are doing so on the basis of states like New York and California and places like that. While Indiana is not very much different from any other state, we don't operate the same. I have also attacked this on the basis that this is illegal because the law is quite clear that the applicant shall give assurance to the state agency that they will do thus and so. It does not say that you have to give 5% or 25% or 2½% or some other percent. It just says that you have to give assurance that this means that I can make a judgmental decision as to whether or not I accept your assurances or not. I have elected to do this. On a claim these are merely guidelines—I am up to my neck in guidelines. This is nothing new to me. They are published as guidelines because they couldn't get them through the Congress. So they make guidelines out of them and the next thing you know the guidelines are saying to you if you don't follow our guidelines you don't get any money.

What is going on which may not be very apparent to you is that consumerism has become the God to which everybody bows in Washington. This should come as no surprise to you as we discussed this in 1966. Most of the conver-

sation I have had with you, and a lot of this came from you, was that if we don't do it, somebody else will. If you haven't caught on yet, medical decisions are now being made in Washington by politicians and not by doctors. It is also happening in the states. It's my contention that you cannot pass a regulation on an intent. It is a law in Indiana that you cannot do this. In other words, I cannot present a regulation to my Board or to any Board and hold hearings simply by saying that when the legislature passed this law they intended that we do something. I think this will apply at the federal level also. It seems now that all proposals are to employ lay individuals in a majority to make many of the decisions which have the effect of limiting the practice of medicine and controlling the health care of the people of this nation.

**QUESTION:** Do you have any reason for believing that a bill for Emergency Medical Services, if introduced, is going to see the light of day or get any farther than it did in previous sessions of the state legislature?

**DR. OFFUTT:** Not unless we do a lot more things than we did the last time. There is no doubt in my mind how the bill got killed last time and no doubt in my mind that it will get killed the same way this time.

**QUESTION:** Would you be opposed to a second bill perhaps being watered down to at least get a foot in the door?

**DR. OFFUTT:** You know what my little grand-daddy said: You had better take a biscuit than miss out on the whole loaf.

## REPORT OF THE EXECUTIVE COMMITTEE

**DR. KERR:** You may remember several years ago there was a proposal that the ISMA and the RMP jointly use the field staff of ISMA. This would be funded out of RMP monies and would be under the control of the Indiana State Medical Association. At the time Dr. Stonehill rejected this proposal rather vigorously. As I understand, his objection was that it would be operated by the Indiana State Medical Association and further that he proposed to make this field staff a composite of field representatives of all voluntary agencies, etc.

There is a new proposal, to wit, that RMP funds amounting to some \$30,000 would be allocated for the purpose of hiring additional fieldmen who would actually work for ISMA, who would also give information about RMP.



DR. INGRAM: If we need more field staff, we should pay for it and not use federal funds that we really don't have any control over. Therefore, I move that we reject such a proposal at this time.

The motion was seconded by Dr. Harshman and discussed.

DR. GOSMAN: I take the opposite point of view that I think we should accept this particular proposal. I think there has been a tremendous revision in the Regional Medical Program. There has been a revision from the standpoint of Dr. Beering now acting as coordinator, and it is quite possible that we will attempt to get Dr. Beering to become the full time coordinator. Those of you who know Dr. Beering I can understand being impressed with his abilities and his dedication to medicine. I personally believe that this is an attempt to increase cooperation between the ISMA and the RMP program and, personally, I have no qualms about accepting federal funds for various things. As a matter of fact, I feel very strongly that we should be running some of these things and taking the funds and hiring the people necessary to run it. I oppose the motion.

DR. HOYT: I don't believe we really have enough information today to make a definite decision. I move to table it until we have more information.

CHAIRMAN: The move to table takes precedence. Tabled until next meeting.

QUESTION: I would like to ask Dr. Offutt if he has any comment on whether we should get mixed up with RMP.

DR. OFFUTT: The general consensus in Washington is that the Regional Medical Program is the program by providers for providers. And you are the providers. I think if you don't get into it, somebody else is going to run it for you.

Neither motion was put to vote and no action was taken on either of them.

DR. KERR: The next item which was brought to our attention was that there are a number of multi-county medical societies. For example: Jefferson-Switzerland; Jackson-Jennings; Harrison-Crawford; Wayne-Union, etc. The By-laws provide that there shall be, whether this is a combined county medical society or not, at least one delegate from each county. It has turned out on a number of occasions that both delegates from such two-county units were from the same county, making one of these delegates illegal. It would appear to us that, if this situation again occurs, one of the delegates will have to be refused a seat or else the By-laws will have to be changed in order to rectify this particular problem.

DR. KERR: There was a little folder that was presented such as this—this particular one came from the Illinois State Medical Society and it is called "Medicare Misconceptions." You all have a copy of this folder and it has been suggested that we should perhaps have some of these printed and have them available for your handing to your patients in your offices, hospitals, or wherever you wish. The cost per 200,000 folders would be \$15 per thousand.

DR. TYRRELL: I have something similar to this in my own office and, let me tell you, you have no idea how this has taken the pressure and burden off the doctor. You can spend hours talking about this program but when I see a patient I just hand this to them. In a very short time we have put out over 100. Just hand this to the patient, go down to the next room and see another patient and then come back; by this time he has read it and, let me tell you, all your arguments and disagreements are gone right there. Some of the best written little pamphlets I have ever seen.

Various costs were discussed and, upon motion duly made and seconded, it was voted that the association buy 20,000 of these pamphlets and send one free to each doctor with an order card permitting him to order additional quantities at the actual cost figure of the pamphlet.

The motion was put to a vote and carried.

DR. KERR: You are aware that the new public law makes provisions for areas of medical need to have assigned to them physicians from the Public Health Corps. These physicians will be paid for through federal government salaries as though they were in the military or in the public health service. In order for an area of need to get such assistance, there has to be a request from the county and it has to be certified by the State Medical Association that such need does exist. We have had to have two telephone conferences in the Executive Committee in order to resolve this on two applications that have been made already. Discussion then came up yesterday as to trying to establish some kind of a firm policy and there are two views. One is that if a county medical society requested that, we then have no alternative but to go ahead and agree and sign the certification. The other view is that each of these situations should be investigated individually and some thought that the county society had already investigated and made the decision or they would not have made the request. We decided that we had better

turn this over to you gentlemen to establish a policy which the headquarters office could use in handling these requests for certification.

The proposal was discussed by Dr. Thatcher, and Dr. Shields went into detail concerning his county's action in this matter.

DR. PETRICH: The number has now risen to 252 physicians available. There are also in excess of 400 nurses enrolled and there are approximately 700 to 800 paramedical people such as technicians in various categories, etc. Really, in terms of numbers of people in delivering health care we are not talking about a lot of people when you spread this out over the country, since it is a national health service corporation. I am not going to talk about people going to a particular area such as Jackson-Jennings, Marion County or whatever. I would like to talk about the principle involved in this whole business of area of need regarding physicians and what position the ISMA should take as far as I am concerned. In the discussion yesterday the executive secretary has had several requests for an endorsement of the state association of a county medical society request for these particular kind of people. These, for the most part, are in lieu of military service time. They are contracted for a specific period—usually two years. The salary schedules for the practicing physician in this corporation will be \$12,000 to \$15,000 and, by implication, and I am now implying, that I don't think you are going to get the greatest doctors in the world for \$12,000 to \$15,000 by and large, with some exceptions. I don't think the Indiana State Medical Association ought to put itself in the position of blanketly endorsing any request from any area of the state without some sort of an investigation to ascertain that there is, in fact, a real need of remedial substantive nature that can be filled by these people and that other mechanisms for providing health care for those areas will insure, such as Jack has said. They hope to have two men coming out who, they hope, will settle there permanently in the area so that there is not a practice area established where there is none or very little and then two years from now these people finish their term of service, they leave the service and go elsewhere to private practice or into another area of need. I don't think we ought to allow our office to function automatically for approval in these cases. I think they ought to be taken on an individual merit basis and that was my position yesterday and it is today.



DR. KERR: I think what we are after here is: Is the state society going to abide by a local county request or are we going to be big brothers?

COMMENT: For further clarification, some of the discussion went this way, that the field men should go out and investigate in the area. It is my contention that the place where investigation should rest is with the county medical society. If the medical society has submitted a request, I don't see how we are in a position to turn them down.

MR. WAGGENER: I brought this up to the executive committee because we have had several inquiries from county societies. We have had requests from Jennings County; we have had one from Marion County—both of which have been approved. The heat is on me now from Rush County to do something in the way of certification of need for that county. I have applications—apparently correspondence between the federal government and doctors in Gary or the Gary Comprehensive Health Planning Council. They come to me, for example, the Jennings County effort was a telegram which I received, and one requesting a reply by telegram. I had a telephone conversation with the executive committee before I could send the certification which was required by the federal government. The telegram was sent but then I was informed the government would not accept this telegram, so I wrote a letter saying the same things I had said in the telegram. The point of it is that apparently these counties that are requesting these certifications come in today and want it right now. I am asking for a policy. What should I do? Should I automatically certify on the basis of a county society request, or what should we do? I don't see how the field staff could go in and make any investigation. The county society has certain powers of its own which I don't think we should abrogate. We are required to certify on account of county request. All I want to know is what I do when these requests come in.

DR. GOSMAN: I would move that, when similar requests are received at the state office, the district representative of the Board of Trustees be notified and he investigate and bring to the next meeting of the Board of Trustees his recommendation for approval or disapproval. The motion was seconded by Dr. Goodman, put to vote and carried.

DR. HARSHMAN: I would like to move that the Headquarters office send out information to each county society informing them of the program pitfalls

and if we have recommendations, so that they can have the information available if the subject comes up. Then when we get called in they will know the answers before we get there.

The motion was duly seconded, put to vote and carried.

DR. KERR: The State Medical Society of Wisconsin makes an award to the Board of Trustees and officers at the time they are inducted into the respective offices. It has been suggested that this might be nice to have for the officers and for the trustees when they take office in the Indiana State Medical Association.

It was duly moved and seconded, put to vote and carried, that such certificates be prepared for the officers and trustees.

DR. KERR: Another matter we have discussed on two previous occasions we are now bringing to you. The A. H. Robins Company has sent a check for \$200 which is to be used as we see fit in the development of professional or scientific matters. The offer was accepted, upon motion of Dr. Dukes and a second by Dr. McIntosh, but violently objected to by your president who went into considerable discussion, so we submit it to you for your decision. Do you accept the \$200 from the A. H. Robins Company to be used for the development of professional or scientific matter or do we reject it?

DR. GOODMAN: I think that these people have specified in their letter that they are depending upon our good judgment, which I think we have, to find a suitable project for which to spend the \$200. I move that we accept it, and that the executive secretary write a letter of thanks to the A. H. Robins Co.

The motion was seconded by Dr. Hoyt, put to vote and carried.

DR. KERR: The executive committee had a request from the Committee on Sports and Medicine to send out a double card for a survey—at a cost of \$300-plus. In their survey they want information to come back from the physicians of the state relative to whether they are participating in Sports and Medicine or whether they would like to be affiliated in this particular field. They have exceeded their budget as of this year. That means we are giving them more. The cost was \$365.25 for the estimate supplied by Dr. Bomba.

DR. WILHELMUS: Being a member of that committee—I think the committee was to include this in our next mailing from the main office, like a newsletter of something, to save the cost.

CHAIRMAN: If this could be done,

Jim, and if it is satisfactory with everybody, we will take it by consent.

DR. KERR: There has been information compiled on use of the building to be published in The Journal. We thought this would be of interest to you. From January through the end of May, the following meetings were scheduled—and this is seven days a week in this building: There have been 51 meetings held in the headquarters office. Included in the above figures are the ISMA Commissions and Committees—37; included also are other related medical groups and specialty societies. In such groups are Directors of Medical Education, Indiana Regional Medical Program, 14 of those. This includes 34 actual days, of 162 days of months of time spent in operation of the headquarters in a five-month period. It can be readily seen that the meeting schedules are on the increase and more and more medical related groups are taking advantage of our excellent facilities.

DR. KERR: We have another request for funds—this from the Commission on Public Information. They would like to make a physician activity file and have this computerized. It would then be kind of a brain-picking file, so that the headquarters office and the officers would know what doctor and what area of the state would be interested and informed on what particular activities. The cost would be about \$600 the first year and this could be set up on a questionnaire basis and then put on a card and key punched so that it could be available at any time.

The matter was further discussed by several and taken as a matter of information and no other action being taken.

DR. KERR: We have another letter for your information from the Joint Commission on Accreditation of Hospitals asking us to report in a confidential manner any problems we see existing in medical staffs in six hospitals which are planned to be surveyed by that organization in the coming months.

Following reading of the contents of the letter it was moved, seconded, put to vote and carried that the association not forward any information of any confidential matter that we may have regarding private practice of physicians, their attitudes and discussions of problems to do with hospitals and staff operation.

The matter was further discussed and it was pointed out that we should not rule out the possibility of the State Medi-



cal Association having some communication with the JCAH to see that the hospitals observe the requirements the staff would like for them to live up to.

DR. PETRICH: I will move that, when approached by the County Society acting as the society with staff problems, that this become a matter for investigation and decision and what have you at the next immediate meeting of the Board of Trustees.

The motion was seconded by Dr. Goodman, and further discussion ensued.

DR. GOSMAN: I would move to amend the motion to read that, should the State Medical Association receive any notification of ill doings or what not from any one of these counties or hospital staffs, we then take necessary steps as implied in the letter.

The motion to amend was seconded by Dr. Santare. Discussion on the amendment ensued and the amendment was put to vote and carried.

CHAIRMAN: Dr. Petrich, will you now restate your motion as amended?

DR. PETRICH: I move that when the State Association is requested by the county society acting for and has coordinate staff, hospital staff, makes a request to us that the Board will then act on forwarding any information to the JCAH on an individual basis and it will then be open at that particular time for all comment and discussion.

Further discussion followed and finally the restated motion was put to a vote and carried.

DR. PETRICH: Mr. Chairman, I would now move to reconsider my original motion dealing with state hospitals. The motion was duly seconded, put to vote and carried.

A poll was taken of the trustees in whose districts the six hospitals are located and none were aware of any particular problems related to the staff or operation of the hospitals.

DR. PETRICH: I would like to make one comment and that is only to remind everyone here that this organization is not, in fact, an organization of hospital staffs. It is an organization of county medical societies representing individual practicing physicians and with that statement I would like to move that the previous motion which we are reconsidering be tabled until the next meeting of the Board of Trustees when these reports are, in fact, brought to us.

The motion to table was carried.

DR. KERR: The question of printing *The Journal* has arisen again. You will

recall it had been acted upon by the Board and we were going to transfer the contract to the Gibbs-Inman Company, where the cost may be a bit more but the service promises to be better. At the request of one of the trustees this was reviewed and there was to be another chance given to the printer in Indiana.

The executive committee recommends that we proceed with the original direction of the Board and that is to change the contract from Graessle-Mercer to Gibbs-Inman Company.

The matter was discussed by Dr. Shields, Dr. Ramsey and others.

DR. PETRICH: The motion which we previously passed left the time of change to the discretion of the executive secretary. I therefore move that we do in fact make the change with the first available issue of *The Journal*.

The motion was seconded by Dr. Wilhelmus, put to vote and carried.

DR. KERR: Dr. Santare previously brought to the executive committee a question raised by a physician from his district concerning the handling of medical records involved in a medical-legal activity.

Apparently in Illinois a doctor has two alternatives—one is to send his records to a central copying agency where original copies of his records are made. The other is that the physician may be subpoenaed under process to take his records to the central agency for copy and certification. We have requested the executive secretary to check this out with our attorneys and I will ask him to report at this time.

MR. WAGGENER: In checking this with our attorneys I find that this is not the method used in Indiana. In our state the records are maintained by the doctor in his office. The attorney goes to the physician and obtains a deposition from him and perhaps reviews the records there. The attorney made the comment that a doctor should never release his original records to anyone and that if a copy is required the physician himself should cause the copy to be made and maintain personal possession of his original records. The attorney pointed out that in a trial in a court room where a doctor might be quoting from his records the opposing attorney has a right to review them in the court room. He does not have a right to copy them.

The matter was further discussed by Dr. Santare and Dr. Tyrrell.

DR. KERR: We give this to you for your information.

DR. KERR: We have passed among you a comparison of dues collected by state medical associations throughout the country. I think you might find it of some interest as we are neither the worst nor the best.

You will also, I believe, find in your possession a legal opinion given by our attorneys on the terms "usual and customary." We give you these for your information.

DR. KERR: We have a letter addressed to Dr. Eli Goodman from Doctor Neathamer which I want to read to you.

At this time it was requested that Dr. Black and Mr. Herbert Dixon be brought into the room to hear the contents of the letter.

Dr. Black and Mr. Dixon were brought in and Doctor Kerr proceeded to read the letter in toto.

CHAIRMAN: I think we will defer decision on this letter until we have the official report from Blue Shield.

DR. KERR: We have an idea which might alleviate the kind of problem Dr. Neathamer makes reference to. This, in essence, is a contract which you and your patient sign and it would be in three parts which would provide evidence to third parties that the patient and physician had discussed fees for the services to be rendered. I would like to point out to you that while this is a sample form it is just a consideration that we are presenting to you and you could design one to fit your own particular type of practice.

This was further discussed by Dr. Goodman, Mr. Waggener and Dr. Ingram.

DR. INGRAM: I do not know about anybody else here, but I object to making a written contract in triplicate to defend myself against an insurance company that advertises itself as the Doctor's Plan and is supposedly under the office of the Indiana State Medical Association or at least a close relationship. All this has arisen out of Resolution 26 that was passed in 1962. If there were no Resolution 26, Blue Shield would not be able to promulgate this sort of disaster and we would not have these discussions every time this Board meets, and it is every time. When the Ad Hoc Committee went around the state we heard this at every place. You know the contact with the insurance company will defend the patient for the remainder of the charges if the physician charges more, etc. Now we are told every time we come around to the Board that this is our insurance company, they are really trying to cooperate with us. Yet here they are in Doctor



Neathamer's office saying either you reduce your fee or we will inform the patient that we will support him legally if he does not wish to pay the rest of it. This is a fine how-do-you-do. I think the one obvious solution to the problem is for this Board to submit to the House of Delegates this October a resolution to rescind Resolution 26.

Therefore, with this for a background, I now move that this Board prepare and submit a resolution to the 1972 House of Delegates of the Indiana State Medical Association to rescind Resolution 26.

The motion was seconded by Dr. Gosman and a discussion by several ensued. Following discussion, a motion was made to temporarily table this motion which was seconded, put to vote and carried.

DR. LEE: I would like to bring up a point before Dr. Kerr leaves with regard to the joint county societies having two delegates from one county. What will be the status at the meeting in October of this year? Wayne-Union has a situation where we have two delegates from Wayne County.

DR. KERR: That is not legal so only one can be seated. You will have to get someone from Union to serve until the By-laws are changed.

DR. PETRICH: A suggestion which I think is a very good one was made by one who cannot make a motion, therefore I will move that a brochure detailing the facts regarding Medicaid, Welfare and allied programs be produced by our office staff for our approval at the August meeting for possible printing and distribution to the members.

The motion was duly seconded, put to vote and carried.

DR. POPPLEWELL (President of the Marion County Medical Society and of the Metropolitan Board): I want to relate, as I have been requested to do briefly, about two programs in which the Marion County Medical Society is involved, or perhaps I should say that has involved the Marion County Medical Society.

Our Society has been involved to a great extent in Comprehensive Health Planning since its origination in Marion County approximately a year and a half ago. Representatives of our Society attending some community meetings which were addressed by Washington officials and these individuals seemed to think they had a brilliant idea to try to select a few places throughout the country where a group of community individuals, including health providers, the consum-

ers and other third parties could sit around with local government and think about how they might provide some type of experimental Comprehensive Health Delivery System. They had money for planning and, soon after, we learned that the City of Indianapolis had indeed submitted a preliminary application without communicating to anybody and this was followed by a series of meetings over a period of months and ending with an agreement on the part of everybody that a grant application for such an exploratory system would be submitted by the Marion County Comprehensive Health Planning Council. This, essentially, provided for a new group to take that portion of the Comprehensive Health Program. Last fall they were funded for \$1,143,000 for a two-year period to do several studies to provide two programs of an experimental nature and the development of a Pediatric Nursing Program. None of the grant money has to do in any way with delivering any care at all. This is basically to provide the community with the opportunity of finding out what is going on at the present time and document this and lay the ground work for possible development of alternative ways of improving what goes on in Marion County.

A new corporation has been formed consisting of 16 members, and the program has been watered down a bit. It has now become, in essence, a comment and review facility for Marion County. Also, they have been given the responsibility by the City of Indianapolis to provide a comment and review activity that the Mayor of Indianapolis is in need of for those programs which come under his purview and, as I understand, he has the sign-off power on all Federal funds coming into Marion County, with the exception of some research projects coming through the University.

Now the other program, which I think more accurately we would say that has involved us, has to do with the Metropolitan Health Council's proposal for the development of an experimental community health network. Going back to about 1968, there was a group of individuals in Indianapolis who evidenced an interest, and they were health providers, in seeing whether or not they could help improve the health of some of the inner city population through experimentation with neighborhood health clinics. In 1968 the Metropolitan Health Council was formed by these individuals as a means of avoiding competition from one group or another going after the same source of funds and to coordinate the

acquisition of funds for this purpose. At the same time, a clinic known as the Martindale Health Clinic was opened on the east side of Indianapolis and this was followed by two additional clinics being opened. The Marion County General Hospital sponsored the Martindale Clinic. The other two were sponsored by Methodist Hospital and for a period of years these clinics were operated under the offices of the home institution but coordinated through the Metropolitan Health Council, which really secured the funds for the operation of these clinics.

Along about the same time that the program proposed by the officials from Washington was under consideration, the Metropolitan Health Council became interested in the possibility of developing some type of an OEO program wherein they could get a lot of money to do certain things in Indianapolis. After a number of meetings it was decided they would apply for a planning grant for the development of an experimental community health network. Our county society has been represented on the health council from its inception but we have only one member. The initial concept was to explore the possibility of having an experimental program for a small number of families who would be receiving their health care paid for by OEO. The original program called for something like 100,000 and after our society took action it was revised to 10,000 and it was to be down on the near east-side of Indianapolis in the inner city where a lot of health needs had been unmet for a number of years.

A little over a year ago they did receive a planning grant for approximately \$93,000 which permitted them to employ a staff and during the subsequent period they have been working on the program which we now have and you can see by the thickness of this book this is worth \$93,000. What has occurred since this has come about as a continuation and expansion of the concept of neighborhood health centers. This has come about because there is a tremendous neighborhood movement in Indianapolis which has been brought on through many of the city programs in order to secure Federal funds. Over a period of a year of negotiating with OEO the Metropolitan Health Council has gotten to the point where they have now selected four areas for the development of the experimental health network. There are two basic concepts—one of them is that the care to be provided must be comprehensive and supplied on the basis of a capitation program, insurance or other-



wise. It makes no difference to the government as long as it is a capitation program. The second is that the providers of health care must agree to assume a part of the risk, that is, the financial risk, in providing this care. Now the care at the present time does not spell out how this risk is to be spread or assumed but nevertheless it is one of the basic concepts. Originally when they started talking they stated they would try to find doctors who would form groups among themselves and go in and assume the responsibility for the poor people being paid for from these funds and also to take care of other patients who have the ability to pay and this would be on a fee-for-service type basis. We doubt they will be able to recruit enough physicians in one full sweep to meet the demand for this type of operation and perhaps this is one of the reasons behind the use now of public health service physicians in this type of area. We understand two or three groups have inquired about these physicians but none have contacted us at this time. We have, however, said that we were interested in support of such projects but this occurred prior to the time when we knew that all of the fees for service were going to be created by somebody besides the physicians and paid back to the government. We have been informed by Region 5 that there has been no approved project from Marion County or from the state of Indiana or for the medical association at that time. We entertained representatives of the Metropolitan Health Council at one of our society meetings but it is difficult in a short period of one meeting to understand all the things that are significant in a document of this size. No action was taken, the program was sent in and we got a letter then from OEO wanting us to respond to the document which has been referred to a committee of our society. Our committee studied this and, while the study was only for a short duration because of the deadline established by OEO, the report of our study committee was approved by our Board at the last meeting.

In essence, we have at the present time said that we do not approve the OEO grant. Our committee felt there were many things not well enough defined in this program. What they have now worked up in the program is approximately coverage for 5,000 people in four centers and of these 5,000 people part of them would be totally paid for by OEO and another part partially paid for by OEO. In order to get that much

money, they also have to enroll people who are apparently having their health care provided through third party mechanisms such as Medicare, Medicaid and private insurance. The big groups they would have to go after is the Medicaid and Medicare group residing out of the areas. Our society, through its committee, could not find any documentation of trying to relate to approximately 14 physicians who generally border the area involved, rather than being right in the center of them, as to how they would relate except that they do provide for the possibility of up to 10% of these people who get their care privately.

They have changed their minds in a manner which has to do with the physicians who would provide health care in these various centers. They are doing it now on the basis that these would be employees of some not-for-profit corporation or group or the center, rather than some form of group practice to carry on the delivery of health care in that particular area.

One of the other problems which concerns our society is not just these centers but the fact that if you are going to have these and use with these centers popping up with no long range planning and the question of transportation in Indianapolis has not been adequately evaluated.

I could spend hours discussing this program further and the so-called insurance or capitation program and what is comprehensive health care, but one can really not measure what they are currently preparing or trying to do. To take 25,000 people of such low economic standard is probably not going to make a whole lot of difference in the private practice of medicine but this is not where it stops. If following the 27 months these are deemed a success, then would come the third grant which would call for further expansion and we already have a lot of unhappy people by turning them down on being a part of this original program.

There are three or four other neighborhood health centers right now ready to go if they could get the funding. In order for these to be successful and in order for the federal government to carry out its objective, they must have a large number of people involved and the private sector will be expected to carry part of this load. This is one of their goals—getting the private sector to join in the capitation fee for these people which will be a high enough rate to offset some of the loss from the poor. I think we could, and I told them that we could

envision that, with a successful program there is a distinct possibility that in the third grant period we are talking about, a program to expand enrollment to 100,000 people, which is 1/8 of the population of the city. The new Metropolitan Health Council has 51% consumers and 1/3 of the consumers are people whose incomes put them into the OEO category. The OEO people have also said that our By-laws must be changed, because individuals who have spent the last four or five years trying to do a job in these neighborhood health centers cannot be on the Board of the Health Council because they have a vested interest. This leads me to believe that doctors will not be elected to be members of the Board. Thank you.

DR. JOHNSON: You received a letter some time ago from the Commission on Public Health signed by me in March of 1972 asking you to consider a plan for reorganization of local health departments in Indiana—a plan which our commission has been working on for a couple of years. I am here to present this in person and Dr. Offutt has come with me to provide technical backing.

The motion for adoption was made by Dr. Gosman, seconded by Dr. Petrich and, following discussion, was put to vote and carried.

DR. GOODMAN: I would propose that this matter be given to a representative committee with two or three members of this Board to study at length and report back with a positive proposal for action.

DR. DUKES: Do I have volunteers? We have volunteers—Dr. Gosman, Dr. Goodman and Dr. Sholty to report back to the next meeting of the Board.

DR. OFFUTT: Sometime ago I reported to you on the matter that the National Communicable Disease Center had issued a recommendation that we no longer have compulsory vaccination.

Dr. Offutt proceeded to explain the position of the State Board of Health and the fact that the writer of the letter was unaware of his facts as far as Indiana was concerned.

On motion of Dr. Gosman and Dr. Petrich, the motion to approve his statement was put to vote and carried.

## REPORTS OF TRUSTEES 1ST DISTRICT

Dr. Wilhelmus: I would like to personally thank the president and president-elect for their attendance at our meeting, as it added a great deal to the session. We had a large turnout, in fact this is



the first year we were forced to turn down reservations.

I notice here that I have a request for the remission of dues for a member, but inasmuch as I have not had an opportunity to investigate this, I would like to postpone this until the next meeting of the Board.

## 2ND DISTRICT

Dr. Dukes: Our meeting has been set for Bloomington in 1973.

## 3RD DISTRICT

Dr. Goodman: Our district voted that our meeting would be changed from May to about September, so our next meeting will be in September of 1973 but the location has not been established.

## 4TH DISTRICT

Dr. Shields: I herewith present my resignation as a trustee effective with this meeting.

The resignation was accepted.

It was announced that Howard C. Jackson, trustee-elect, will fill out the unexpired term in addition to his regular term.

Dr. William F. Blaisdell was elected the alternate trustee.

## 5TH DISTRICT

Dr. Schauwecker: We had a fine meeting on May 24th at the Terre Haute County Club, at which time Dr. Owsley talked on Peer Review, Dr. Murray on HMOs and Dr. Corcoran on Medical Foundations. Unfortunately, it was not as well attended as we had hoped it would be. Last year we raised the dues to \$10, which we thought would stimulate attendance. Perhaps it did but not as much as we had anticipated. In the election Dr. James Lett of Greencastle was elected president. The next meeting will be on May 27th in Greencastle at the Windy Hill Country Club.

## 6TH DISTRICT

Dr. Glen Ward Lee: We had a very good attendance for our meeting in Shelbyville and had practically the same program on Peer Review, Foundations and HMOs. Our 1973 meeting will be in Rushville but I am not sure of the date at this time.

## 7TH DISTRICT

Dr. Schuster: I have requests for remission of dues of two members, both of whom are ill and have requested remission of their dues for this year. I move that their dues be remitted. The

motion was duly seconded, put to vote and carried.

## 8TH DISTRICT

Dr. Ingram: We had our meeting on June 7th. The president, president-elect, the executive secretary and the field secretary were all present. Dr. David Dietz of Muncie was elected president and Dr. Art Gray of Muncie the secretary-treasurer. We had an election for trustee and I was reelected. For the balance of the term of the alternate trustee who resigned, Dr. Jack Alexander was elected to fill the unexpired term of Doctor Williams. We had Doctor Bowen as our afternoon speaker and we had a tremendous crowd, which was very unusual for our district meeting.

## 9TH DISTRICT

Dr. Sholty: Our meeting is to be held June 28th in Lebanon.

## 10TH DISTRICT

Dr. Santare: Dr. Thomas Tyrrell being an alternate delegate to the AMA, he felt that the job of alternate trustee should be spread among other able men and he elected not to run for the position of alternate trustee. As a result, Dr. Martin O'Neill of Valparaiso was elected to succeed Dr. Tyrrell following the October meeting. Dr. Fitzpatrick was elected to succeed Dr. Shapiro as a Blue Shield Board member whose term expires in March of 1973.

It was also voted to increase our district dues from \$1 to \$3 per year.

## 11TH DISTRICT

Dr. Harshman: There is a possible change in our meeting date. It was originally scheduled for September 20th to be held in Kokomo. It will probably be held one day later. We had intended to have the columnist Bill Buckley address us but since this is impossible we have not established a definite program at this time.

## 12TH DISTRICT

Dr. Clark: I have a request for remission of dues for two of our physicians. They are both ill and unable to practice. Therefore, I move remission of their dues.

The motion was seconded, put to vote and carried.

Dr. Clark: I was asked to investigate the request for medical defense from a doctor in my district. This physician had not filed a request for assistance until after he had incurred a legal services bill of \$851. The association has written

him on several occasions informing him of his constitutional rights and sent him blanks but for some reason or other he never responded, so I think we will have to go back and tell the young man he will have to pay the fee himself as he has not abided by the Constitution and By-laws.

Chairman: If there are no objections to this, we will turn down payment of the claim. It was taken by consent.

Dr. Clark: The last thing I would like to report is that our meeting is scheduled to be held September 14th. We hope to have a great party. We will have Dr. Annis as our speaker.

## 13TH DISTRICT

Dr. Gattman: Our meeting will be held September 13th at the Michigan City Country Club. We still have not selected a speaker.

I want to comment that Dr. Petrich made a trip to visit with several society meetings in my district and I want to say he was very well received and they were quite enthusiastic that an officer of the association would make such a trip for this purpose.

Chairman: We will now move on to item 8 (b).

Dr. Wilhelmus: No further report.

Dr. Dukes: No additional report from the 2nd district.

Dr. Goodman: I have some problems in our district in regard to Blue Shield.

Chairman: We will bring that up later.

Dr. Shields: No further report.

Dr. Schauwecker: No further report from the 5th district.

Dr. Lee: No additional report.

Dr. Schuster: I have another report which I will take up later if it is alright with the chair.

Dr. Ingram: I forgot to report that our meeting date for next year is in June, I think it is the 5th but I will have to check. It will be held in Muncie.

Dr. Sholty: No further report.

Dr. Santare: No additional report.

Dr. Harshman: No further report.

Dr. Clark: No additional report from the 12th district.

Dr. Gattman: No further report.

Chairman: We will now call on Dr. Dahling, Chairman of the Commission on Public Information.

DR. DAHLING: Dr. Dahling presented a placard which the Commission proposes to send to physicians for display in their offices, giving pertinent messages regarding health insurance, etc. He also informed the Board the Commis-



sion was going to request a \$10 dues increase to be earmarked strictly for use in public relations.

The idea of the placard was discussed by several.

DR. CLARK: I move that the placard program be put into motion by January 1, 1973.

The motion was seconded by Dr. Petrich, further discussed by several, put to vote and carried.

CHAIRMAN: We will now have the reports from committees and commissions.

DR. SCHUSTER: I have been authorized by the Chairman of the Commission on Special Activities to bring this Board a request for the purchase and distribution of a pamphlet, the object of which is to bring about some practical education and practical means for the physicians of the state of Indiana to do something about drug abuse.

We intend to make this a tear-out section in *The Journal* and, according to the figures we have, it would cost \$116.37. There might be some additional cost because we have in mind also including a tear-out questionnaire which physicians could return to the state office. The purpose of this questionnaire is that we are trying to find out what the physician who is out in practice thinks about the problem. Does he think there is a problem and does he have a specific type of question, because if we could get some information from the men out in the state down to the state committee, we could perhaps provide a better program to be of use to the physician.

I would like to move, Mr. Chairman, that the Board approve the expenditure of the money which I would estimate to be between \$125 to \$175 for this program.

The motion was seconded by Dr. Goodman, put to vote and carried.

Membership Report: The membership report was approved by consent.

DR. SHIELDS: Mr. Chairman, I would like to report on the assignment given me to report back to the Board on Resolution 71-3 introduced in the 1971 session by Delaware-Blackford Medical Society.

I have no recommendation on this resolution and return this to the Board with no recommendations from the committee.

The matter was discussed by Dr. Ingram, Dr. Shields, Dr. Dukes, Dr. Petrich and others.

DR. SHIELDS: For discussion purposes, I will move that we accept the resolution as printed.

The motion was properly seconded by

Dr. Ingram. Discussion followed and Dr. Shields was requested to restate his motion.

DR. SHIELDS: I move that we accept this resolution and that it be referred back to the committee for consideration or rewording. Further discussion was made and Dr. Ingram proposed an amendment as follows:

DR. INGRAM: I would move to amend the section beginning Now Therefore Be It Resolved, following the word "to hereby notify the members of the Federal congress and the general public" striking the remainder of the resolve and adding at that point the following: "that we will recommend that our members not participate in any Federal sponsored plan of socialized medical care now under consideration or any other such plan which may in the future be considered."

The proposed amendment was seconded by Dr. Petrich, put to vote and carried.

DR. DUKES: We are now ready to vote on the motion as amended and this will be a roll call vote.

Dr. Wilhelmus—yea  
Dr. Goodman—nay  
Dr. Shields—yea  
Dr. Schauwacker—yea  
Dr. Lee—nay  
Dr. Ferrara—yea  
Dr. Schuster—nay  
Dr. Ingram—yea  
Dr. Sholty—yea  
Dr. Santare—yea  
Dr. Harshman—yea  
Dr. Clark—yea  
Dr. Gattmann—yea  
Dr. Petrich—yea  
Dr. Gosman—yea  
Dr. Hoyt—nay

The motion carries—the vote is 12 to 4.

MR. WAGGENER: We have \$733 in the Indiana National Bank balance in the Student Loan fund and we are wondering if it is necessary to keep this open or may we transfer this to the savings account.

By consent, the secretary was authorized to transfer this account to the savings account.

CHAIRMAN: We will now have a report from Dr. Black, Chairman of the Board of Blue Shield.

DR. BLACK: Reviewed the financial situation of the Blue Shield Plan and stated that they had lost about 2% of the membership over the past year but had a 22% increase in the amounts added to the reserves. He also pointed out that their management costs had gone up to around 7%. Dr. Black discussed the supposed report prepared from the

Legislative Council and plans for a retreat for the members of the Board of Blue Shield in an effort to better inform them of the operation of the program.

Also discussed was Resolution 26, the cash flow of the company, and commented on questions concerning complaints by physicians coming before the full Board of Blue Shield and the difference in payments between general practitioners and specialists.

Considerable discussion was had between several members of the Board and Dr. Black concerning the usual and customary concept to Resolution 26 and the way it is administered by the Blue Shield Plan.

Also discussed were the letters which Blue Shield had been sending to patients as well as to physicians, the Board pointing out that this is creating a bad public relations situation, not only between the doctor and the patients, but also between the doctor and Blue Shield.

CHAIRMAN: We will now hear from Mr. Dixon to discuss the two letters that Blue Shield has in mind using.

MR. DIXON: Presented several changes in terminology of letters they propose to send to patients of doctors throughout the program and this was thoroughly discussed by all. The point was also brought up in discussion regarding what is the definition of a prior understanding between the doctor and the patient.

DR. GOODMAN: I would like to read a letter I have from one of the constituents of my society concerning the operation of Blue Shield.

Dr. Goodman proceeded to read the letter and, following the reading of the letter, moved that the Board of Trustees offer a resolution to the House of Delegates in the October meeting to disassociate the ISMA with the Blue Shield program.

Motion was seconded by Dr. Ingram and discussion ensued.

During discussion it was pointed out that this should be a matter handled locally and the resolution from the county medical society to the House of Delegates rather than a request to the Board of Trustees to make such a resolution.

DR. INGRAM: I would move to table this motion until the next meeting and rediscuss it. The motion was properly seconded, put to vote and carried.

DR. PETRICH: I move that we remove from the table the motion we have tabled temporarily this morning—the motion about disavowing Resolution 26 made by Dr. Ingram earlier and temporarily tabled.



The motion was seconded by Dr. Ingram, put to vote and carried.

Dr. Goodman then discussed several activities within his district and the great credibility gap which, in his opinion, exists between Blue Shield and practicing physicians. He said that the physicians in his district felt that Blue Shield was not updating their figures and this was creating considerable problems in his district.

The matter was discussed by Mr. Dixon, Dr. Goodman, Dr. Gosman, Dr. Dukes, with the suggestion being made that these matters should be referred to the Blue Shield Board members in that respective district.

DR. PETRICH: We have a legal opinion regarding this whole business if you would like to get to it to get focus on the operation involved rather than a particular incident in certain cases. I think we have to get back to talking about Resolution 26 and the resolution and legal counsel's report which specifically gives determination legally in an opinion form about what this whole thing is about. We are getting one side of the story from the gentleman over here, and justifiably so, because they are representing the policyholder. I think we are here to determine what our position is in relation to the company and that is what we ought to be talking about.

DR. GOSMAN: May I ask one question? Would your problem with Blue Shield have been easier if the Indiana State Medical Association had a relative value schedule?

DR. BLACK: Personally, I believe yes.

A lengthy discussion then followed concerning the method Blue Shield uses in establishing fees for physicians under its various programs.

DR. INGRAM: We have a motion on the floor. I haven't discussed the motion at all. I would like to call attention to this legal opinion from our legal counsel.

Dr. Ingram proceeded to read the legal opinion.

DR. PETRICH: I will make one statement now. Blue Shield in the institution of the Medicaid and Medicare program in the State of Indiana has done absolutely no business in usual and customary office visits yet arbitrarily decided what usual and customary office visits were. Later they upgraded or downgraded them and I asked the other night at the 10th District meeting from Mr. Dixon how you go about getting your profile updated to the 1970 level, which is now permissible under the regulations formulated by the government. I didn't get a decent answer. The question has been asked a dozen times today—where do you get your usual and customary charges—and I think that is the crux of the matter and this legal opinion, I think, is a very important thing and something we should have brought up sooner today.

The matter was further discussed by Dr. Petrich, Dr. Ingram, Dr. Tyrrell, Mr. Dixon, Dr. Dukes, Dr. Butler.

The question was then asked to Dr. Black when Resolution 26 was adopted did not Blue Shield go out to the county medical societies and obtain agreements with county medical societies to accept the Blue Shield preferred schedule as a full payment plan? How many of those agreements are still in existence?

Further discussion was held without the question being fully answered.

DR. INGRAM: I move that we submit a resolution to the House in this session rescinding Resolution 26. The motion was seconded by Dr. Gosman.

The question was called and the motion was put to vote, the Chairman asking for a show of hands, and the vote proved the submission of resolution was seven to five. The chair announced that the vote did not carry for lack of a majority.

Further discussion ensued regarding

the legality of the ruling of the chair and the motion was made to sustain the chair.

DR. PETRICH: I move that this be tabled until the next meeting.

The motion was duly seconded, put to vote and carried.

DR. PETRICH: Mr. Chairman, I would like to make a motion that, between now and the next meeting, Dr. Santare, Dr. Ingram and Dr. Harshman be a committee of three to review Resolution 26 and report the facts as they determine them to the Board for discussion to be made at our next meeting.

The motion was seconded by Dr. Gosman, put to vote and carried.

DR. GOODMAN: I would move that we have stickers printed to be placed on the telephone of every physician in the state of Indiana announcing the fact that the Indiana State Medical Association is a service organization and listing the WATS line number for their use. I would judge this would cost us between \$100 and \$150.

The motion was seconded by Dr. Gosman, put to vote and carried.

Dr. Sholty raised a question about the association filing counter suits in some malpractice cases.

On motion being made and duly seconded, this was referred to the Executive Committee.

DR. HARSHMAN: I would like to move that the president, the president-elect and chairman of the Board, trustees, and chairman of the Commission on Medical Economics and Insurance reinstitute their monthly meeting with the Blue Shield Board committee. I don't believe that the committee has been functional for at least two years and I would like to see that committee back in action.

The motion was seconded by Dr. Goodman, put to vote and carried.

Their being no further business on the agenda, it was agreed to meet again at 8:30 a.m. on Sunday, August 6, 1972.



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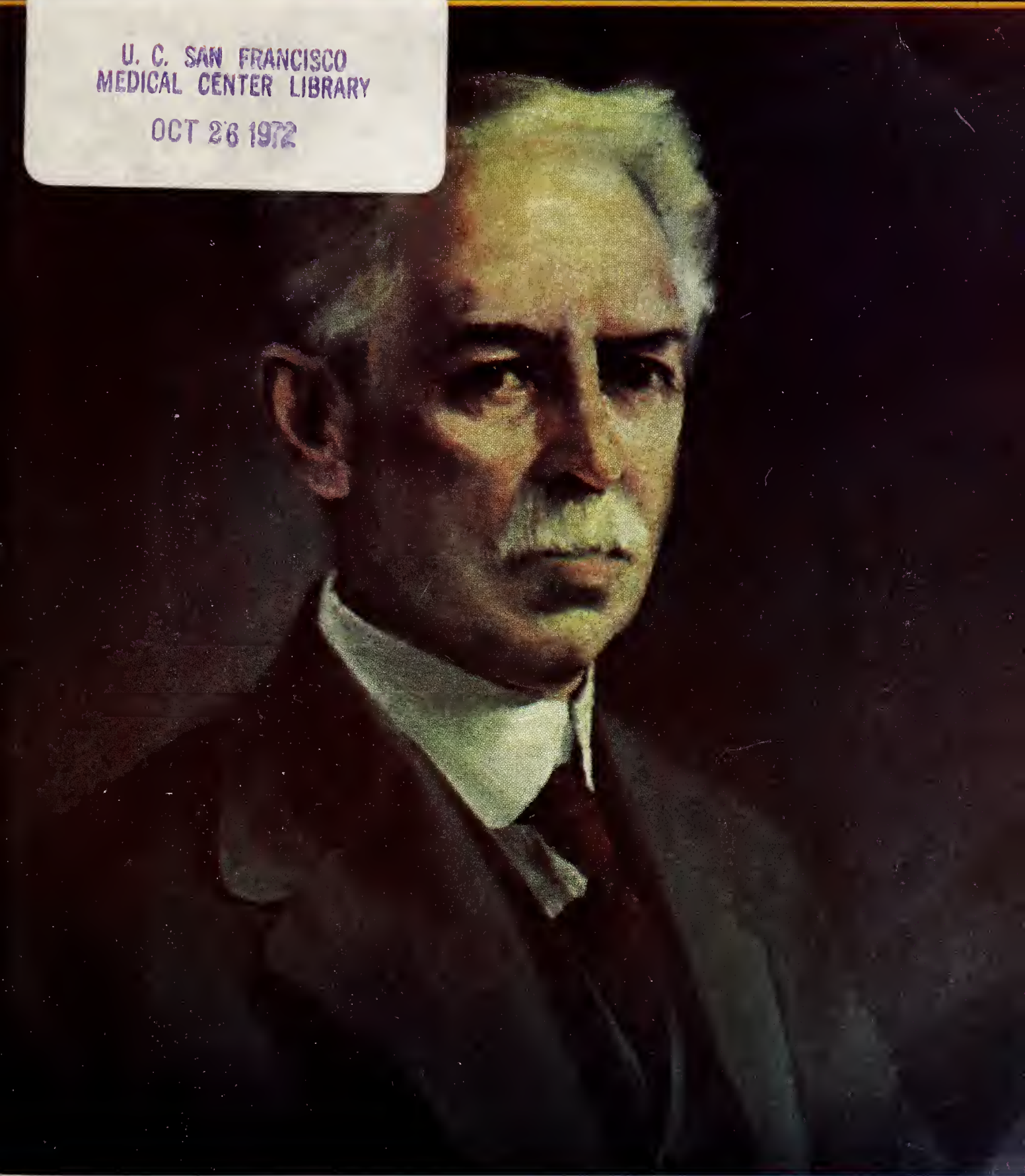
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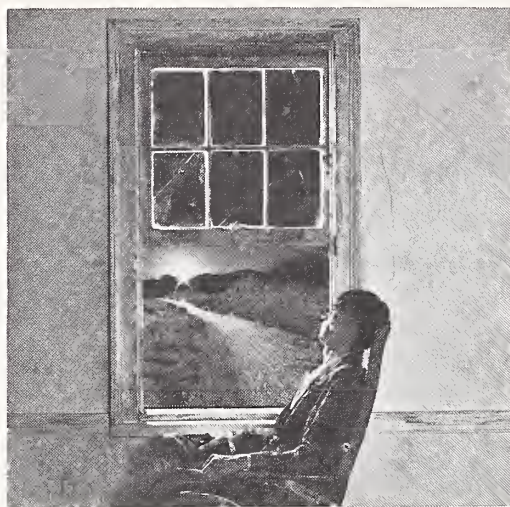
**pentazocine** (as hydrochloride)

the long-range analgesic



# a new outlook in chronic pain

of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

**Usage in Pregnancy.** Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

**Drug Dependence.** There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

**Acute CNS Manifestations.** Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

**Usage in Children.** Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Ambulatory Patients.** Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

**Myocardial Infarction.** As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

**Biliary Surgery.** Until further experience is gained with the effects

of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

**Patients Receiving Narcotics.** Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

**CNS Effect.** Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no causal effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequent constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequent flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration: Adults.** The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

**Children Under 12 Years of Age.** Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Duration of Therapy.** Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage: Manifestations.** Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

**Treatment.** Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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50 mg. Tablets

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the long-range analgesic





# MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

**T**HE Republican platform for the 1972 presidential campaign has planks opposing compulsory national health insurance and legalization of marijuana.

The Democratic platform advocates a national health insurance program for all Americans financed and administered by the federal government. It does not mention the marijuana issue.

The American Medical Association's recommendation on the Republican health care plank was presented by Donald E. Wood, M.D., (Indianapolis) a member of the AMA Board of Trustees, at a convention subcommittee hearing before the platform was drafted.

Dr. Wood expanded on a "theme of priority setting and realistic acknowledgment of fiscal limitations."

"We believe that this is the only possible foundation for sound public policy in setting our health and other national goals," Dr. Wood said.

"In setting our health goals, it is not necessary to destroy a system that has given this nation its high level of health and scientific achievement. Our goals will be best attained by building upon the strengths of this system. What is necessary is that all of us—government, public, and the professions—work together to find solutions that will not only meet the needs of today but will assure a system that even more successfully will meet the needs of tomorrow."

## Text of Republican health care planks

Our goal is to enable every American to secure quality health care at reasonable cost. We pledge a balanced approach—one that takes into account the problems of providing sufficient medical personnel and facilities.

Last year President Nixon proposed one of the most inclusive health programs in our history. But the opposition Congress has dragged its feet and most of this program has yet to be enacted into law.

Continued

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6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
7—Dwight W. Schuster, Indianapolis	Oct. 1972
8—Richard Ingram, Montpelier	Oct. 1972
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—Lowell Hillis, Logansport	Oct. 1972
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

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District	Term Expires
1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—Cleon M. Schauwecker, Greencastle	1973
6—Glen Ward Lee, Richmand	1975
7—Joseph F. Ferrara, Frankin	1972
7—Joseph C. Kerlin Danville	1972
8—Jack L. Alexander, Muncie	1973
9—Max N. Hoffman, Cavington	1974
10—Thomas C. Tyrrell, Hammond	1972
11—James A. Harshman, Kokomo	1974
12—Walter D. Griest, Fort Wayne	1974
13—Danald S. Chamberlain, South Bend	1973

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1.	Bernard B. Rosenblatt, Evansville	Jahn Winebrenner, Evansville	May 10, 1973, Evansville
2.		J. S. Brown, Carlisle	Bloomington
3.	Claude J. Meyer, Jeffersanville	Robert K. McKechnie, Jeffersanville	September 1973, Clarksville
4.	Kenneth Schneider, Calumbus	C. David Ryan, Calumbus	Columbus
5.	James C. Lett, Greencastle	J. Franklin Swaim, Rockville	May 23, 1973, Greencastle
6.	John Maenning, Greenfield	Davis W. Ellis, Jr., Rushville	May 2, 1973, Rushville
7.	Donald E. Stephens, Indianapolis	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	June 6, 1973, Muncie
9.	Lawell R. Stephens, Covington	Theadore C. Person, Veedersburg	June 14, 1973, Attica
10.	Lambra Dimitroff, Hammond	Maria D. Mansueta, Munster	May 30, 1973, Hebron
11.	John Elleman, Kokomo	Fred Poehler, La Fontaine	Sept. 20, 1972, Kokoma
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterlaa	September 14, 1972, Fort Wayne
13.	Frank McGue, Michigan City	David L. Spalding, Mishawaka	Sept. 13, 1972, Michigan City



MONTH IN WASHINGTON

Continued

To increase the supply of medical services, we will continue to support programs to help our schools graduate more physicians, dentists, nurses, and allied health personnel, with special emphasis on family practitioners and others who deliver primary medical care.

We will also encourage the use of such allied personnel as doctors' assistants, foster new area health education centers, channel more services into geographic areas which now are medically deprived, and improve the availability of emergency medical care.

We note with pride that the President has already signed the most comprehensive health manpower legislation ever enacted.

To improve efficiency in providing health and medical care, we have developed and will continue to encourage a pluralistic approach to the delivery of quality health care including innovative experiments such as health maintenance organizations. We also support efforts to develop ambulatory medical care services to reduce hospitalization and keep costs down.

To reduce the cost of health care, we stress our efforts to curb inflation in the economy; we will also expand the supply of medical services and encourage greater cost consciousness in hospitalization and medical care. In doing this we realize the importance of the doctor-patient relationship and the necessity of insuring that individuals have freedom of choice of health providers.

To assure access to basic medical care for all our people, we support a program financed by employers, employees and the federal government to provide comprehensive health insurance coverage, including insurance against the cost of long-term and catastrophic illness and accidents and renal failure which necessitates dialysis, at a cost which all Americans can afford. The National Health Insurance Partnership plan and the Family Health Insurance Plan proposed by the President meet these specifications. They would build on existing private health insurance systems, not destroy them.

We oppose nationalized compulsory health insurance. This approach would at least triple in taxes the amount the average citizen now pays for health and would deny families the right to choose the kind of care they prefer. Ultimately it would lower the overall quality of health care for all Americans.

We believe that the most effective way of improving health in the long run is by emphasis on preventive measures.

The serious physical fitness problem in our country requires urgent attention. The President recently reorganized the Council on Physical Fitness and Sports

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MONTH IN WASHINGTON

Continued

to increase the leadership of representatives of medicine, physical education, sports associations and school administrations. The Republican Party urges intensification of these efforts, particularly in the nation's school systems, to encourage widespread participation in effective physical fitness programs.

We have initiated this nation's first all-out assault against cancer. Led by the new National Cancer Institute, the drive to eliminate this cruel killer will involve Federal spending of nearly \$430 million in fiscal year 1973, almost twice the funding of just two years ago.

We have launched a major new attack on sickle cell anemia, a serious blood disorder afflicting many black Americans, and developed a comprehensive program to deal with the menace of lead-based paint poisoning, including the screening of approximately 1,500,000 Americans.

We support expanded medical research to find cures for the major diseases of the heart, blood vessels, lungs and kidneys—diseases which now account for over half the deaths in the United States.

We have significantly advanced efforts to combat mental retardation and established a national goal to cut its incidence in half by the year 2000.

We continue to support the concept of comprehensive community mental health centers. In this fiscal year \$135 million—almost three times the 1970 level—will be devoted to the staffing of 422 community mental health centers serving a population of 56 million people. We have intensified research on methods of treating mental problems, increasing our outlays from \$76 million in 1969 to approximately \$96 million for 1973. We continue to urge extension of private health insurance to cover mental illness.

We have also improved consumer protection, health education and accident prevention programs. And in Moscow this year, President Nixon reached an agreement with the Soviet Union on health research which may yield substantial benefits in many fields in the years ahead.

Excerpts from Republican drug abuse planks

The permissiveness of the 1960s left no legacy more insidious than drug abuse. In that decade narcotics became widely available, most tragically among our young people. The use of drugs became endowed with a sheen of false glamour identified with social protest.

By the time our nation awakened to this cancerous social ill, it found no major combat weapons available.

Soon after we took office, our research disclosed there were perhaps hundreds of thousands of heroin

Continued

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# ISMA Committees and Commissions for 1971-1972

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Continued

users in the United States. Their cravings multiplied violence and crime. We found many more were abusing other drugs, such as amphetamines and barbiturates. Marijuana had become commonplace. All this was spurred by criminals using modern methods of mass distribution against outnumbered authorities lacking adequate countermeasures.

We quickly launched a massive assault against drug abuse.

We intercepted the supply of dangerous drugs at points of entry and impeded their internal distribution. . . .

To inhibit the distribution of heroin in our own country, we increased the law enforcement budget for drug control more than 10 times—from \$20 million to \$244 million. . . .

We established the “Heroin Hot Line”—a nationwide toll free phone number (800/368-5363)—to give the public a single number for reporting information on heroin pushers. . . .

To alert the public, particularly the youth, to the dangers of drugs, we established a National Clearinghouse for Drug Abuse Information in 1970, as well as a \$3.5 million Drug Education and Training Program.

We realize that the problem of drug abuse cannot be quickly solved, but we have launched a massive effort where practically none existed before . . .

We pledge to seek further international agreements to restrict the production and movement of dangerous drugs.

We pledge to expand our programs of education, rehabilitation, training and treatment. We will do more than ever before to conduct research into the complex psychological regions of disappointment and alienation which have led many young people to turn desperately toward drugs.

We firmly oppose efforts to make drugs easily available. We equally oppose the legalization of marijuana. We intend to solve problems, not create bigger ones by legalizing drugs of unknown physical impact.

We pledge the most intensive law enforcement war ever waged. We are determined to drive the pushers of dangerous drugs from the streets, schools, and neighborhoods of America.

**New Flu Vaccine on Horizon**

A new kind of flu vaccine has been developed by government scientists containing live viruses that they believe holds hope of greatly containing future influenza epidemics.

The vaccine still must be put through extensive tests and trials, before being licensed for use on the public.

But scientists who reported the development were hopeful that this could be done before the next major expected U.S. flu epidemic in the latter part of the decade.

In their research at the National Institute of Allergy and Infectious Diseases of the National Institutes of Health in Bethesda, Md., the scientists said they employed the live, though weakened, viruses in developing the vaccine.

The scientists performed a laboratory trick to produce an immunity to the flu with the live viruses without causing the disease itself.

The trick involved creating a hybrid virus that cannot stand the heat of the lungs, where it could bring about the disease. This hybrid, however, thrives in the lower temperatures of the nose and throat, where it produces protection against the flu.

The new vaccine was given as a nasal spray instead of an injection.

None of the 17 persons given the new type of vaccine in tests caught the influenza even when exposed to it. But 17 of 28 not given the vaccine caught the influenza.

None of the 17 given the new vaccine suffered any of the side effects associated with presently used killed virus vaccines—wooziness, headaches, a low fever and slight nausea.

**Joint American—Soviet  
Research Project Expanded**

Top American and Soviet health officials announced they will expand a joint health research project to include viral diseases, provision of health services, and occupational health.

The action was taken under a May 25 agreement between the two countries to cooperate in studying cancer, heart disease and environmental problems. Groundwork for the program was laid by President Nixon and Soviet leaders at the Moscow summit meeting.

The broadened agreement was described at a briefing by Soviet health minister Boris V. Petrovsky and Dr. Roger O. Egeberg, co-chairman with Petrovsky of the U.S.-Soviet Joint Committee on Health Cooperation.

“All manner of obstacles are being removed and a very solid foundation built for cooperation between the two countries,” said Petrovsky in summing up the joint program.

Petrovsky also said the group has under advisement a suggestion by President Nixon, with whom he met earlier, to add arthritis to the joint research program.

HEW Secretary Elliot L. Richardson also said Dr. Bertram S. Brown, Director of the National Institute of Mental Health, will visit the Soviet Union in September to discuss schizophrenia research.

Continued



Three experimental cancer drugs developed in the Soviet Union will be given trials of effectiveness on American patients starting early next year.

Richardson, underscoring his attitude of caution about the prospective benefit of the drugs, said that they were new and had not been widely tested.

The drugs, which have not been used clinically in the United States, are:

Fluorodopan, which Soviet scientists have used for treating lymphomas, cancers of soft tissues.

Diiodobenzotepa, a drug the Russians have used for treating cancers of the thyroid and bladder.

Asaley, which Russian doctors have used in the treatment of over 200 cases of lymphoma, breast and ovarian cancer.

The United States also is sending the Soviet Union three experimental drugs:

Hexamethylmelamine, which has been tried against lung cancer.

CCNU, an agent that has been used for a variety of types of cancer.

DTIE, which has been used against a type of skin cancer called melanoma.

The patents to all six drugs are owned by the respective governments.

## Sterilization Popular but Couples Under 30 Prefer "The Pill"

Sterilization became the most popular form of birth control for couples over age 30 during the last half of the 1960's, but younger couples still preferred "the pill," a government-financed study shows.

The 1970 National Fertility Study, conducted under contract with the National Institutes of Health's Center for Population Research, also provided fresh evidence that increased use of contraceptive devices was "a major factor in the drop in the nation's birth rate," which now is at an all-time low.

Although nearly six million married women were using oral contraceptives in 1970, "one of the most dramatic findings" was that voluntary sterilization was preferred more often than "the pill" by both black and white couples in which the wife was aged 30-44.

"The jump in reliance on surgical procedures, and the fact that contraceptive sterilization had by 1970 become the most popular method among older couples, appears to reflect the unsuitability of other methods of contraception for many couples who have already had all the children they want to have," said the first published report from the study.

It was written by Charles F. Westoff of Princeton University, former executive director of the Commission on Population Growth and the American Future.

"It is estimated that as of 1970, some 2.75 million couples of reproductive age (15-44), and undoubtedly many more since 1970, had resorted to sterilization, which is usually regarded as an extreme solution to the problem of fertility control," Westoff wrote.

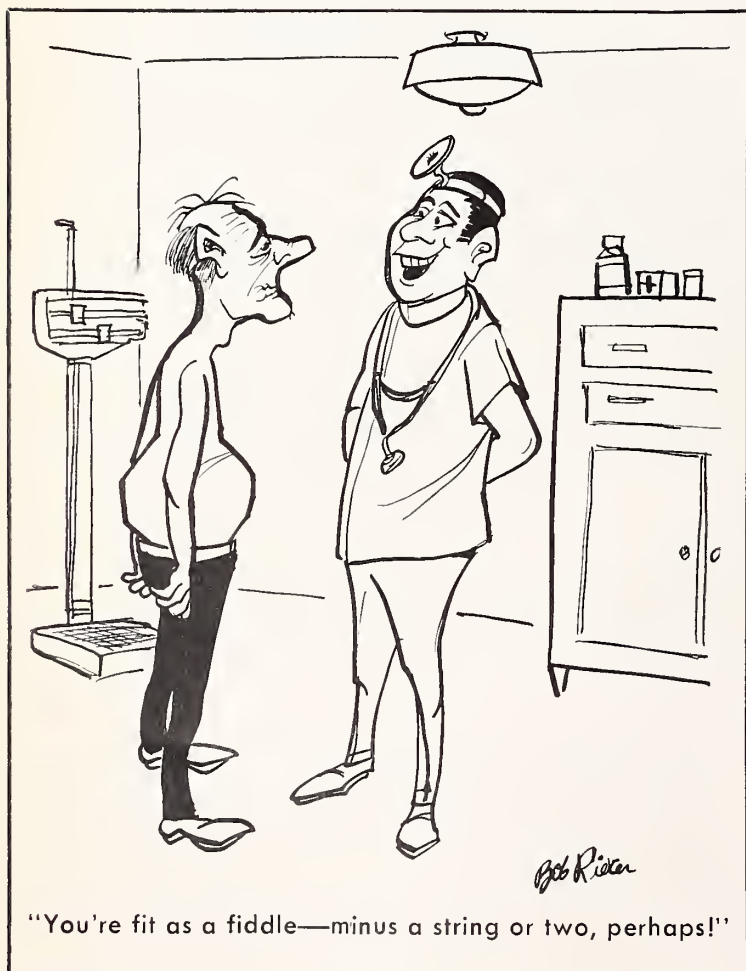
Sterilization was more common among older black couples using contraceptives than among older white couples, he said, but the black male was far less likely to have been sterilized than the black female or either of the white marriage partners.

"There is a considerable difference between black and white women in their belief that a vasectomy will impair male sexual ability," Westoff wrote.

The report, based on nationwide interviews with 5,884 married women under age 45 and compared with a 1965 fertility study, said there was little change in the overall proportion of couples using contraception but significant changes in the methods used.

Sharp increases were reported in use of "the pill," which remained the most popular contraceptive, sterilization and the intrauterine device, but a decline in use of condoms, diaphragms, the rhythm method, withdrawal and douche.

"The adoption of the pill by American women has been an amazing phenomenon, considering the various side effects associated with its use and is an indication of the wide market for effective contraception," he concluded.





*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug  
products useful in treatment  
involving concomitant use  
of two or more drugs?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**62.9%**

**Believe combination drug  
products are useful.**

**13.8%**

**Do not believe combination drug  
products are useful.**

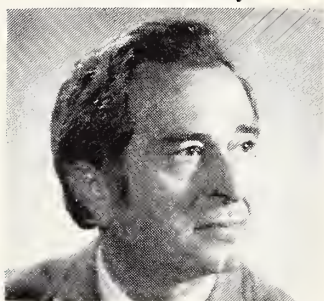


# Are combination drug products useful in treatment involving concomitant use of two or more drugs

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in for a number of years that have an apparently satisfactory track record.

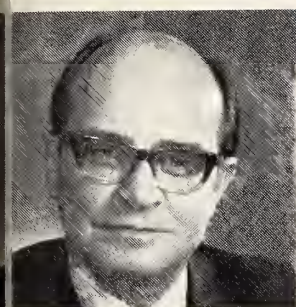
For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosing errors. To take such preparation off the market doesn't seem to be good medicine, unless actual age showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it's avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

W. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact, to insist they always be described separately. To avoid the appearance of pedantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he imparts a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the best of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational. Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

We would welcome your comments.



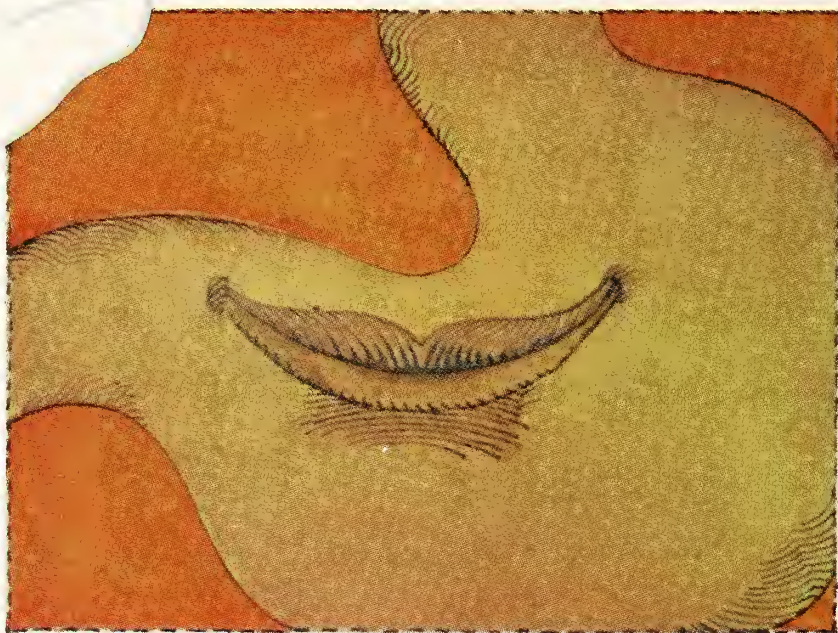
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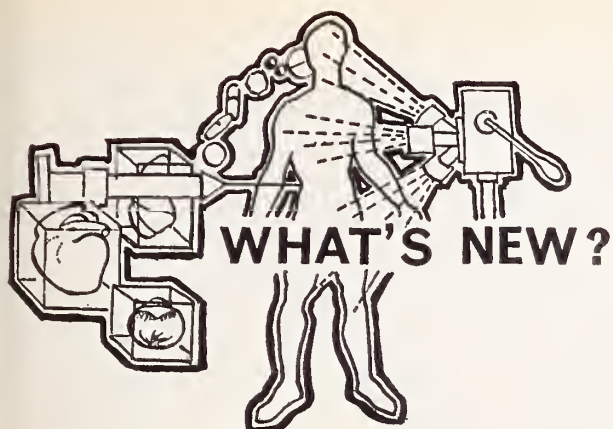
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Parke-Davis has a new "synthetic skin" for treatment of second and third-degree burns. The new dressing combines a polytetrafluoroethylene film and polyurethane foam mesh. It allows air and moisture to pass through to the burned area but not liquids or bacteria. It accelerates the removal of dead tissue, preserves the patient's plasma, and speeds growth of new skin.

\* \* \*

Eli Lilly has announced that all consumer packages of aspirin, aspirin-containing products, and Darvon products are being bottled with safety-closure caps. Larger dispensing packages will have conventional closures but will be labeled "Container not for household use." Safety closures will be the push-down, turn-off type and the turn-off type. Federal requirements for safety closures are that 85% of children under 51 months of age will not be able to open the closure, but that most adults will. Elderly or handicapped adults may, on request, be furnished with easily opened packages.

\* \* \*

Parents Handbooks of Seattle has released a book titled "Call The Doctor About Children." It is written by a pediatrician, Robert F. L. Polley, M.D., for the information of parents. The text furnishes basic information on the care of children but does not treat diagnosis and therapy; 164 pages, \$3.00. Write Parents Handbooks, 1197 112th Avenue N.E., Bellevue, Wash. 98004.

\* \* \*

Howmedica announces that FDA has approved marketing on an expanded basis of Surgical Simplex®, a type of methyl methacrylate bone cement. Surgical Simplex has been marketed for use in hip prostheses. The new permission will sanction its sale for use in knee prostheses.

\* \* \*

Upjohn announces a new brand of ampicillin. The trade name is Pensyn. It is supplied in capsules, in a flavored powder for oral suspension, and in ampules for parenteral use. Capsules are in 250 mg or 500 mg strength. Safety for use of Pensyn in pregnancy has not been established.

\* \* \*

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or a recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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*Frank B. Wynn, M.D., D.Sc.*

*1860-1922*

*Eminent Physician, Teacher,*

*Citizen. A Lover of Nature*

CHARLES A. BONSETT, M.D.  
Indianapolis

THE title for this paper is to be found in bronze on a wall of the main floor at Methodist Hospital in Indianapolis. It was placed there in 1923 by Dr. Frank Wynn's colleagues and dedicated on January 14 of that year with an address by Dr. William N. Wishard who eulogized Dr. Wynn's noble life.

Frank Barbour Wynn was born near Brookville, Indiana, on May 28, 1860. He received his A.B. degree from DePauw University (then known as Asbury College) in 1883. He received his M.D. degree from the Medical College of Ohio in 1885, his A.M. (in chemistry) from DePauw in 1886, and his D.Sc. (an honorary degree) from the same university just one month before his death, which occurred on July 27, 1922.

The 62 years of Dr. Wynn's life were crowded with achievement. His life could not be characterized more succinctly than by the few words found on the bronze tablet

at Methodist Hospital. He made lasting contributions to all his fields of endeavor, and his life provides an inspiring chapter in the history of Indiana medicine, worthy of emulation by later-day generations of Hoosier physicians. He was a quiet, kind, capable, energetic man of many talents who generously shared with others the fruits of his labor. He was highly esteemed by his colleagues, most of whom are now gone. Few physicians who pass his bronze marker today are aware of the man or of the many beneficial things he did. It seems appropriate at this time, the 50th anniversary of Dr. Wynn's death, to recall the salient events of his exemplary life.

Dr. Wynn served an internship at the Good Samaritan Hospital in Cincinnati, this position being obtained by competitive examination. Following this, he spent five years as house physician in the state hospital systems of Ohio and In-

diana, first at Dayton and later at Logansport, where he came under the tutelage of Dr. Josiah Rogers and Dr. Sam Smith, distinguished neuropsychiatrists who would later head what is now the American Psychiatric Association (Dr. Smith was later to become the first chancellor of the Indiana University School of Medicine). It was this extensive experience in state hospital work that qualified Dr. Wynn as a teacher of neurology and psychiatry. Along with Dr. William Baldwin Fletcher, Dr. Albert E. Sterne, and Dr. Ernest Reyer, he was part of the original teaching staff when the amphitheater of the Old Pathology Building (on the grounds of Central State Hospital) was new and opened to the students of the Medical College of Indiana and the Central College of Physicians and Surgeons. This was at the turn of the century.

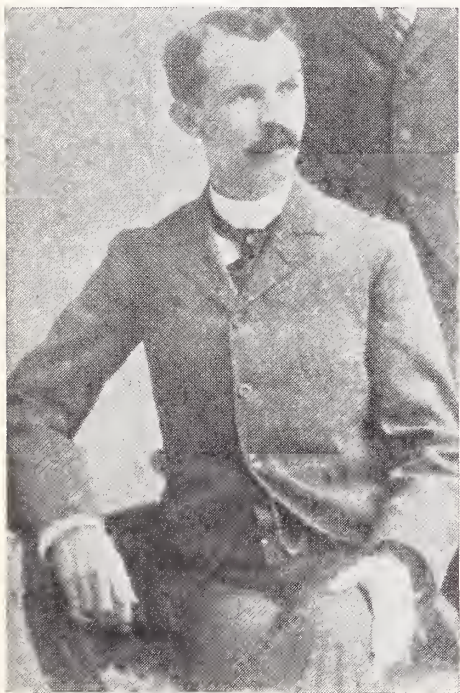
The physician looking for a good postgraduate education before the



turn of the century turned to Europe and especially to Germany for this experience. Dr. Wynn spent most of the years of 1892 and 1893 in Vienna and Berlin. It was here that he became an expert pathologist. He studied in Vienna where Carl Rokitansky had made the subject of gross pathology into a major basic science earlier in the century. Dr. Wynn then went to Berlin where Rudolph Virchow, the father of cellular pathology, was still teaching.

Dr. Wynn, who was later to spend his professional life in the private practice of internal medicine, was profoundly impressed with the importance of a knowledge of pathology to the practice of internal medicine. He compared the importance of this subject for the diagnostician to that of anatomy for the surgeon. Throughout his entire professional life he would stress the importance of the postmortem examination to the understanding of a disease process. It seems ironic that his own unusual death was not explained, even though this study was done.

It was in the fall of 1893 that



DR. FRANK WYNN as a young man in his twenties.

Dr. Wynn settled in Indianapolis and opened an office for the practice of medicine in the former library building which stood on the southwest corner of Pennsylvania and Ohio Streets. He joined the Marion County Medical Society which then held weekly meetings in the basement of the Courthouse.

The average physician of that era had been exposed to a very limited formal education. He would have had the benefit, probably, of a high school education (although it was not mandatory), but he probably would not have had any college work prior to his medical school experience. The medical school itself was limited to a total time of two or three years. (A medical degree was easier to earn at that time than was a bachelor's degree.) Most doctors had not served an internship and had not been exposed to any type of formal postgraduate education.

The county medical societies were the principal agencies for furthering the physicians' knowledge. The Marion County Medical Society at this time devoted one night per month to the subject of pathology. Members were urged to bring in gross specimens for demonstration, and to provide case reports for clinical correlation. This activity was already in progress when Dr. Wynn became a member of the Society. He did not initiate the program (as has sometimes been stated), but his superior education and experience, and, above all, his enthusiasm for the subject soon put him in the forefront in this regard.

In order to develop and further encourage the Society's role in this educational endeavor, Dr. Wynn offered his services gratis at any hour if the attending physician would only get the consent for the study. His reputation was becoming established. The members of the Society were quick to appreciate the wisdom of his concepts. Dr. Wynn

was soon appointed to the staff of the Medical College of Indiana as professor of pathological anatomy. He was also appointed the first city sanitarian for the city of Indianapolis.

The Medical College of Indiana was located at that time at the northeast corner of Maryland and Pennsylvania Streets (where the Majestic Building now stands). It contained the most valuable collection of medical books west of the Allegheny Mountains, known as the "Bobbs Library" in honor of Dr. John Bobbs who was one of the original founders of the school in 1869. Bobbs, who had performed the world's first cholecystotomy, donated his own personal collection of books and an endowment (after his death) which made the library possible. The college also contained a pathology museum which was one of the finest teaching collections in the Mississippi Valley, containing specimens prepared by Bobbs, Parvin, Mears, and other early surgeons. In the early morning hours of November 3, 1894, the medical school caught fire and was completely devastated. The Indiana Medical Journal reported that the collections of over 30 years were "smoke and ashes and cannot be replaced." Both the library and the pathology museum were destroyed.

Dr. Frank Wynn triumphed over both losses. A new medical school was already being constructed at the northwest corner of Market Street and Senate Avenue (where the State Office Building now stands) thanks to the generosity of Dr. William Lomax of Marion, whose bequest had made the new school possible.

Dr. Wynn urged his colleagues to cooperate in the development of an even better museum. The goal was soon achieved. Dr. Wynn sought specimens from his colleague



throughout the state. The number of specimens multiplied.

This collection was exhibited at the annual meeting of the Indiana State Medical Association in 1898 which was held that year in Lafayette. Medical exhibits at that period of time were commercial. The teaching exhibit was almost an unknown entity. It is not surprising, therefore, that Dr. Wynn's exhibit was received with enthusiasm. Indiana physicians were quick to endorse the display because they recognized and appreciated its teaching value. The following year the State Medical Association held its meeting at Indianapolis in the German House (now known as the Athenaeum) and the exhibit was presented again, this time being enlarged to include sections on bacteriology, Indiana medical history, and photography (the camera for the latter section is still to be found in the photographic laboratory of the Old Pathology Building).

This 1899 presentation was received with even more adulation than that of the preceding year. The Hoosier physicians felt that this was too valuable a show to keep for home consumption only. They felt also that this was something that would impress eastern physicians as a notable contribution. The Indiana State Medical Association paid the expense of transporting and exhibiting the displays the following week to Columbus, Ohio, where the American Medical Association was holding its annual meeting.

The response was even more overwhelming. It was determined that such an exhibit should become a part of the annual meetings. Dr. Frank Wynn was appointed secretary of the Committee on Scientific Exhibit and he participated in the annual exhibits for many years thereafter. This was the origin of the Scientific Exhibit Program of the annual meeting of the American Medical Association, which is the

world's largest, most comprehensive, and easily the best educational exhibit to be found anywhere today. It had its origin in Dr. Frank Wynn.

Letters of congratulation poured in. Among others were those from Dr. Rudolph Virchow from Berlin, and from Dr. William Osler who, with others, was making Johns Hopkins University into the force which would soon convert American medical schools into bastions of teaching excellence.

During the period of time that Dr. Wynn was developing the pathology museum and exhibits he was also developing a new medical library. The library was not housed in the new medical school building but rather was located on the second floor of the Indianapolis Public Library, which was then located on the southwest corner of Meridian and Market Streets (where the Hilton Hotel now stands).

Many of the city's physicians, including Dr. Wynn, had offices in the same neighborhood, and the local medical society had taken up permanent quarters in the Willoughby Building, which was just north of the library on Meridian Street. The library was thus conveniently located for the practicing physician and for the medical society. In addition, it was accessible not only to the students of the Medical College of Indiana but also to the students of the highly competitive Central College of Physicians and Surgeons, and to any other medical student or physician.

Dr. Wynn believed in having one library and in making it as large and as extensive as possible. He solicited contributions from physicians throughout the state. This, then, was the origin of the Mear's Collection, the volumes from Theophilus Parvin, and numerous others. The new library was more extensive and complete in its various journals than was the old Bobbs Library, and the books were more



DR. FRANK WYNN as a mountain climber.

numerous and modern.

With the construction of the present Indianapolis Public Library on St. Clair Street in 1917, the Medical Library was moved to the new site. By this time Dr. Wynn was the dominant member of yet another committee, one to honor the memory of Dr. Johns Bobbs. Arrangements were made with a western sculptor from Idaho, Gutzon Borglum, himself the son of a physician, to fashion a life size bas-relief of Dr. John Bobbs. (Borglum was to become world famous in a few years for fashioning the heads of Lincoln, Washington, Jefferson and Theodore Roosevelt from Mount Rushmore in South Dakota).

The Bobbs tablet was completed and placed in the south wall of the east room on the second floor of the library. Here it was surrounded by the thousands of volumes of medical journals and books collected by Dr. Wynn, a most magnificent and appropriate memorial to Dr. Bobbs.

With the passing of time Indiana University School of Medicine moved to the present campus and into the building now known as Emerson Hall. Here another medi-



cal library developed, this time tax-supported, which ultimately made the Indianapolis Public Library collection small and obsolete by comparison. At the present time these medical books in the Public Library are all gone. The bas-relief memorial of Dr. Bobbs remains, however, and it serves as well as a silent tribute to the work of Dr. Wynn.

The amalgamation of the two Indianapolis schools with the Fort Wayne Medical College to form a state-operated medical school, first by Purdue University and later by Indiana University, was achieved at a cost of much bitterness and rancor on the part of those associated with the various schools. It is a striking tribute to Dr. Wynn's character and to his ability that he was chosen to be a member of the committee which effected the merger of all schools to form the Indiana University School of Medicine. This was a most difficult job. It was well done. He continued to serve his new school, until his death, in the Department of Medicine as professor of medical diagnosis.

There were many interests other than the practice and teaching of medicine. Dr. Wynn was a member and president of the Indiana Nature Study Club. He was a member of the Mazamas, a mountaineering and nature study club in Portland, Ore., which was instrumental in preserving numerous areas in the West now known as National Parks or Forests.

While pursuing his postgraduate education in Europe, Dr. Wynn developed a passion for mountain climbing. Among others, he had climbed the Jungfrau and Mount Blanc. He made annual treks to the American West, especially to Glacier National Park, where he had climbed almost all the peaks, being the first to scale many of them. He was an expert climber.

Closer to home, he was a member of the Society of Indiana Pioneers

and of the Indiana Historical Commission, being founder and vice president from its beginning in 1915 until 1921 when he became president. (This is the present Indiana Historical Society). He was also the initiating spirit, driving force, and chairman of the Indiana Centennial Celebration Commission.

The Nancy Hanks Lincoln State Park was another of Dr. Wynn's concepts. Just one month before his own demise he took a group of interested people to the Lincoln Birthplace Memorial near Hodgenville, Ky., and here "in this solemn historic presence" formed the Indiana Lincoln Memorial Association, of which he was elected president.

The following month Dr. Wynn was at Glacier National Park again for his annual mountain climbing jaunts. On the morning of July 26 he set off in company with Dr. Henry Goddard of Columbus, Ohio, to climb Mount Siyeh.

The men left from the Many Glacier Hotel, hiking with packs on their backs toward their destination. By noon they had reached Morning Eagle Falls where they had lunch. By sundown they had reached Piegan Pass. They camped at this point and were on their way again soon after sunrise. Dr. Wynn was in good spirits. On this fateful day the men were making their way along a ledge, Dr. Wynn in the lead, looking for the appropriate spot to start the ascent to their final destination. Dr. Goddard described the experience in these words:

"He (Dr. Wynn) came to a point where he said, 'I don't know which is the better way — to go along the rocks nearly horizontal or to climb up to the next shelf.' He chose the latter. The horizontal way was entirely feasible, as I could see. I could not see the other as I was a few feet below him and to the left, but he evidently thought it better to climb up to the next shelf. He put

his knee on the rock and seemed to start up. I was about to step to where he had been standing when he seemed to step back and the next instant fell headlong backwards to the shelf below — perhaps six feet down. He rolled off this and on down the mountain for quite a distance. He could not have slipped because there was no difficulty to cause a slip, and had he done so he would have easily recovered himself. . . . He made no sign of an effort to save himself. He uttered no sound. I was looking at him all the time and jumped to help but could not reach him — so quick was the movement. Moreover, he had let go of his ice axe, which he almost certainly would not have done had he been conscious as it would have been his greatest aid to recovery.

"I at once descended to where he lay on the rocks. He was not breathing nor was there any sign of pulse or other sign of life."

Had Dr. Wynn experienced a cerebral or coronary thrombosis? transient ischemia? akinetic seizure? There were no facilities for post-mortem study or embalming in the Park. The body was recovered and returned to Indianapolis by train. A postmortem study was then done, but the delay in performing the test and the autolysis that had by then occurred precluded a definite answer to the cause of death of this most remarkable man.

Dr. Wynn never made it up Mount Siyeh but his name has been attached forever to an adjacent peak. The peak originally designated as Point Mountain by George Bird Grinnel on his map of 1885-92 was re-named Mount Wynn in 1927 in honor of Dr. Frank Barbour Wynn, the second physician in our Indiana history to have a mountain bearing his name (Dr. John Evans, also identified with the Old Pathology Building, was the other).

The present paper does not consider Dr. Wynn as lecturer, photog-



rapher, poet, writer (medical and otherwise), deacon and church worker. These and most of the other activities mentioned in this paper were things that Dr. Wynn did in his *spare* time. He was primarily engaged in the full-time private practice of medicine, itself a most demanding activity, but not a subject of this paper. How he managed to do so many things and to do them superbly is a distinguishing characteristic which sets him apart from most of us.

It seems appropriate in closing this 50-year anniversary tribute to Dr. Wynn to recall his words on the occasion of reporting to the Indiana State Medical Association in 1899 about the exhibit at Columbus, Ohio: "The establishment of a Historical Department in connection with the exhibit has seemed wise . . . *The Archives of the State Medical Society should become the reposi-*

*tory for valuable medical relics."* This recommendation has not been followed to the present time.

The Marion County Medical Society will introduce a resolution at the annual meeting of the Indiana State Medical Association in October 1972. This will urge the acceptance by the Association of the Indiana Medical History Foundation, Incorporated, a not-for-profit tax-exempt organization which would achieve this goal and link the present generation of Hoosier physicians to their past.

To date, the Indiana Medical History Foundation has saved the Old Pathology Building on the grounds of Central State Hospital ("Hoosier Medicine's 'Little Red Schoolhouse' —*JISMA* 64:1, 1971), has had the building accepted and listed on the Historic American Building Inventory Survey, and accepted on the National Register of Historic Places

by the Department of the Interior, which places a Federal mantle of protection on the building. (This is the first building used by Indiana University to be so recognized.) In addition, the Foundation has been collecting the medical antiques of Indiana medicine from University and private sources, and also paintings and photographs.

The Old Pathology Building has the potential of becoming a museum of national as well as of regional significance. But it will require the cooperation of physicians throughout the state to effect this. In so doing we will not only save our heritage, we will also pay tribute to our professional forbears — the men who gave us our school (and there were many of them), devoted and dedicated men like Dr. Frank B. Wynn. ◀

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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—August 1972

Disease	Aug. 1972	Jul. 1972	Jun. 1972	Aug. 1971	Aug. 1970
Animal Bites	1263	1345	1732	1305	1175
Chickenpox	57	123	436	24	20
Conjunctivitis	176	205	260	138	125
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	18	22	38	20	55
Gonorrhea	907	866	1114	647	753
Impetigo	174	182	159	128	190
Infectious Hepatitis	39	51	50	37	52
Infectious Mononucleosis	40	44	73	34	29
Influenza	1138	688	565	279	338
Measles					
Rubeola	16	37	115	20	5
Rubella	33	44	68	51	60
Meningococcic Meningitis	0	0	1	1	3
Meningitis, Other	1	0	9	3	2
Mumps	35	50	82	57	63
Pertussis (Whooping Cough)	60	10	4	3	14
Pneumonia	205	213	382	158	220
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	672	708	903	539	418
Syphilis					
Primary & Secondary	48	17	13	20	34
All Other Syphilis	83	93	157	100	114
Tinea Capitis	6	2	3	1	5
Tuberculosis (Active)	53	35	59	47	70

### From THE JOURNAL 50 Years Ago

During the past five years the attention of the profession has been drawn more and more to the use of radium therapy notwithstanding the fact that the early results obtained were based almost exclusively upon the treatment of hopeless or inoperable cases. Encouraged by the marked regression in nearly all cases, even in those which were very advanced, the use of radiation has been extended to the more favorable types with a corresponding increase in the number of apparent cures. The reports from the larger clinics are so favorable for radiation that the question is now acute as to whether carcinoma of the cervix should be considered a surgical disease. This question applies likewise to the early cases as well as to those moderately advanced.

The low percentage of cures following operative removal must be due to the failure of total extirpation of the primary growth, or to the fact that metastasis has occurred before the time of operation. The writer has found that metastasis occurs in some of these cases although clinically there is no reason to suspect such extension has taken place. This metastasis frequently occurs in the spine, the pubic bones, or in the femur, and if radiographs are made of these parts systematically, prognoses will be much more accurate and the course of treatment may be directed more intelligently. It is unfair to the patient to submit her to prolonged irradiation or to an exhausting radical operation for carcinoma of the cervix when at the same time she has carcinoma in some distant part.—Stanley A. Clark, M.D., South Bend, "The Treatment of Carcinoma of the Uterine Cervix, *JISMA*, October 1922.



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**\*Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $> 5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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## IN EDEMA\* — IN HYPERTENSION\*



# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**<sup>®</sup>).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**<sup>®</sup>).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**<sup>®</sup>).

Age 21, short, mammosome, with normal menses, some acne. Was put on pre-nuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**<sup>®</sup> or a sequential).





Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

\*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. has recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E\*** or **Ovulen\*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen\***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen\***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen\***).

**Ovulen**<sup>®</sup> a balanced center-spectrum O.C. for most

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Each pink tablet in Ovulen-28<sup>®</sup> and Demulen<sup>®</sup>-28 is a placebo, containing no active ingredients. Both Ovulen and Demulen are available in 21- and 28-pill schedules.

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**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov) 1969.

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The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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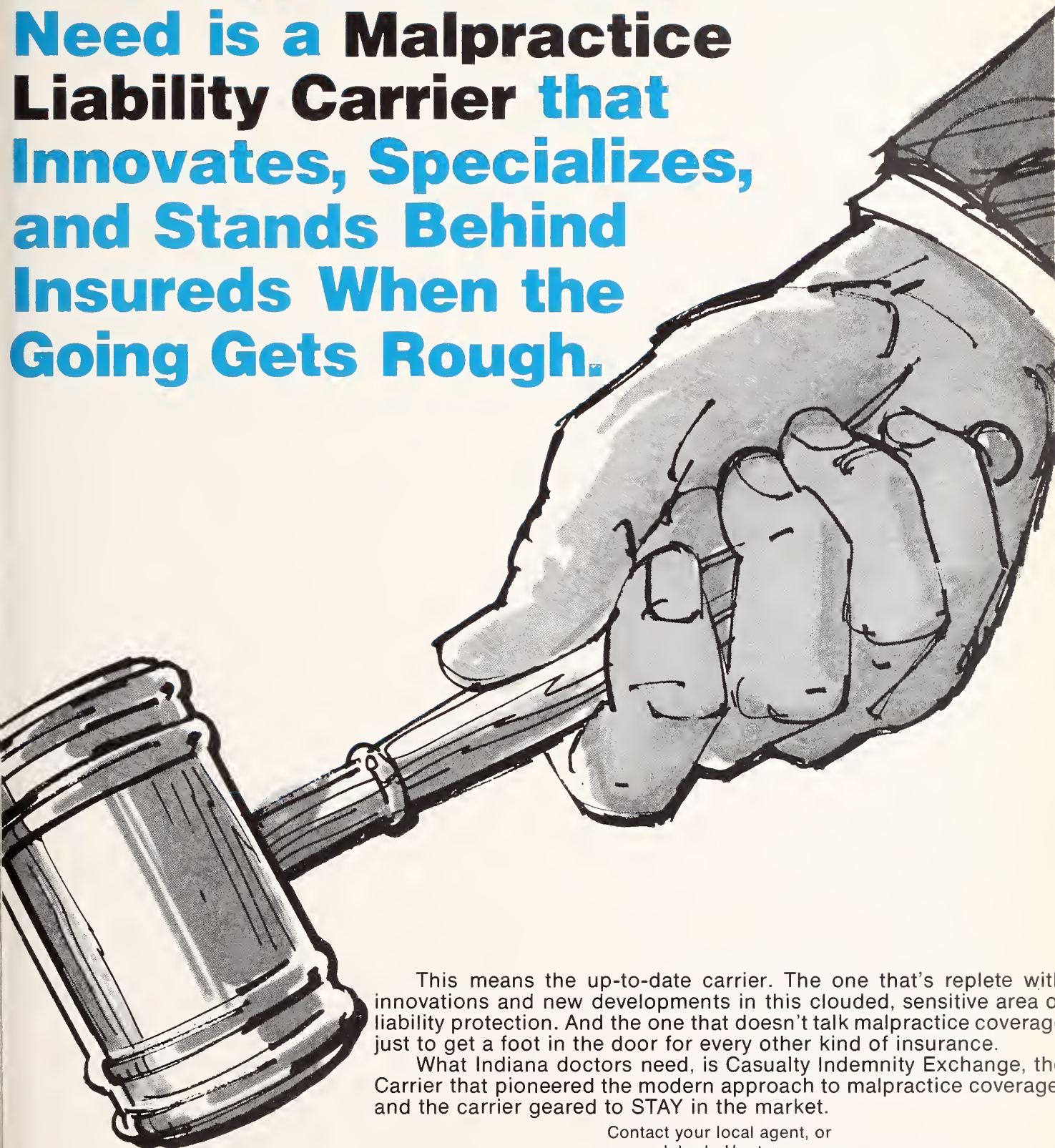
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# Prevention of Dissipation of Health Services Resources\*

SIDNEY R. GARFIELD, M.D.  
Oakland, California\*\*

I'M sure you all know U.S. medicine is in serious trouble. Shortages of manpower, unavailability of services and runaway costs are creating tremendous pressures for legislation, most of which focuses on national health insurance and prepaid group practice patterned after Kaiser-Permanente as a solution.

National health insurance will only make matters worse. The present medical crisis was precipitated by Medicare and Medicaid and the surge of demand they produced. It is sheer folly to believe that compounding that demand by expanding health insurance to the entire population will improve matters—on the contrary, further overtaxing the faltering delivery system will certainly deteriorate the quality and availability of care for the sick.

As for prepaid group practice—though it is flattering to have part of our program proposed as a model for this nation's future delivery system—it is a mistake to believe that it will automatically solve very much. There is nothing inherent in prepaid group practice that guarantees ready availability of service. In fact, this has been as serious a problem with us as in practice in general. Prepayment makes medical care a right by eliminating fee-for-service, and

for years we have been deeply concerned with our relative ability to keep up with the soaring demand that this right produces, and to maintain a level of service satisfactory to us.

Striving to solve this problem and improve our services, we have uncovered a basic defect in the delivery system that has somehow passed unnoticed by us and the rest of the medical world. Recognizing this defect and its cause is extremely important, since its correction is the key to solving most of this nation's medical care problems and leads to a great opportunity for all of us.

Let us first consider the traditional medical care delivery system (Figure 1). Customarily, the patient decides when he needs care. This more or less educated decision by the patient creates a variable mix input composed of well, "worried-well," "early-sick" and sick people. In traditional practice the patient enters knowing he is to pay a fee. The processing unit consists of individual discrete medical care resources (doctors, labs, x-rays, hospitals, etc.). The output is a cured patient—hopefully.

The Kaiser-Permanente program alters that traditional medical care delivery system in just two ways. It eliminates the fee for service, substituting prepayment, and it structures the discrete units of medical care resources into a well-organized group practice in integrated clinic and hospital facilities. Much of the economic advantages of our Plan derives from this organization. However, it should be pointed out this

does not arise from group practice per se, but rather from the total integration of doctors, clinics, hospitals and ancillary services.

The defect we have uncovered is related to the elimination of fee. The obvious purpose of the fee is to remunerate the doctor. It has a less obvious but important side effect: it is a potent regulator of flow into the delivery system. Since nobody wants to pay for unneeded medical care, there is a tendency to put off seeing the doctor until one is really sick. This limits the number of people seeking entry, particularly the well and early sick. Conversely, the sicker a person is, the earlier he seeks help—regardless of fee. Thus, the fee-for-service regulator (Figure 2) limits quantity, minimizes the well and early sick and maximizes the sick in the entry mix. With the input of fee-for-service predominantly sick people, the system that has evolved over the years to match that input is a sick-care delivery system, with the doctor at the point of entry and deeply involved in every step of the sick-care process. Likewise, our medical schools have evolved concentrating on teaching sick-care technology.

Elimination of the fee has always been a primary objective of our Plan since it acts as a barrier to early entry into sick care. Early entry is essential for early treatment and prevention of serious illness and complications. It is distressing to realize that elimination of fees can be as much of a barrier to early care as the fee itself. The reason is that when we removed the fee, we

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removed that regulator of flow into the system. The result is a massive uncontrolled flood of the entire variable mix—the well, the worried well, the early sick and the sick—into the point of entry (the doctor's appointment) on a first-come, first-served basis that has little relation to priority of need. The impact of this demand overloads the system and, since the well and worried well are a large component of that entry mix, their usurping of doctor time actually acts as a barrier to entry of the sick.

This same thing is happening to medical care throughout the country. The traditional delivery system, which has evolved under fee for service, is being overwhelmed because of the elimination of personally paid fees through the spread of health insurance, Medicare and

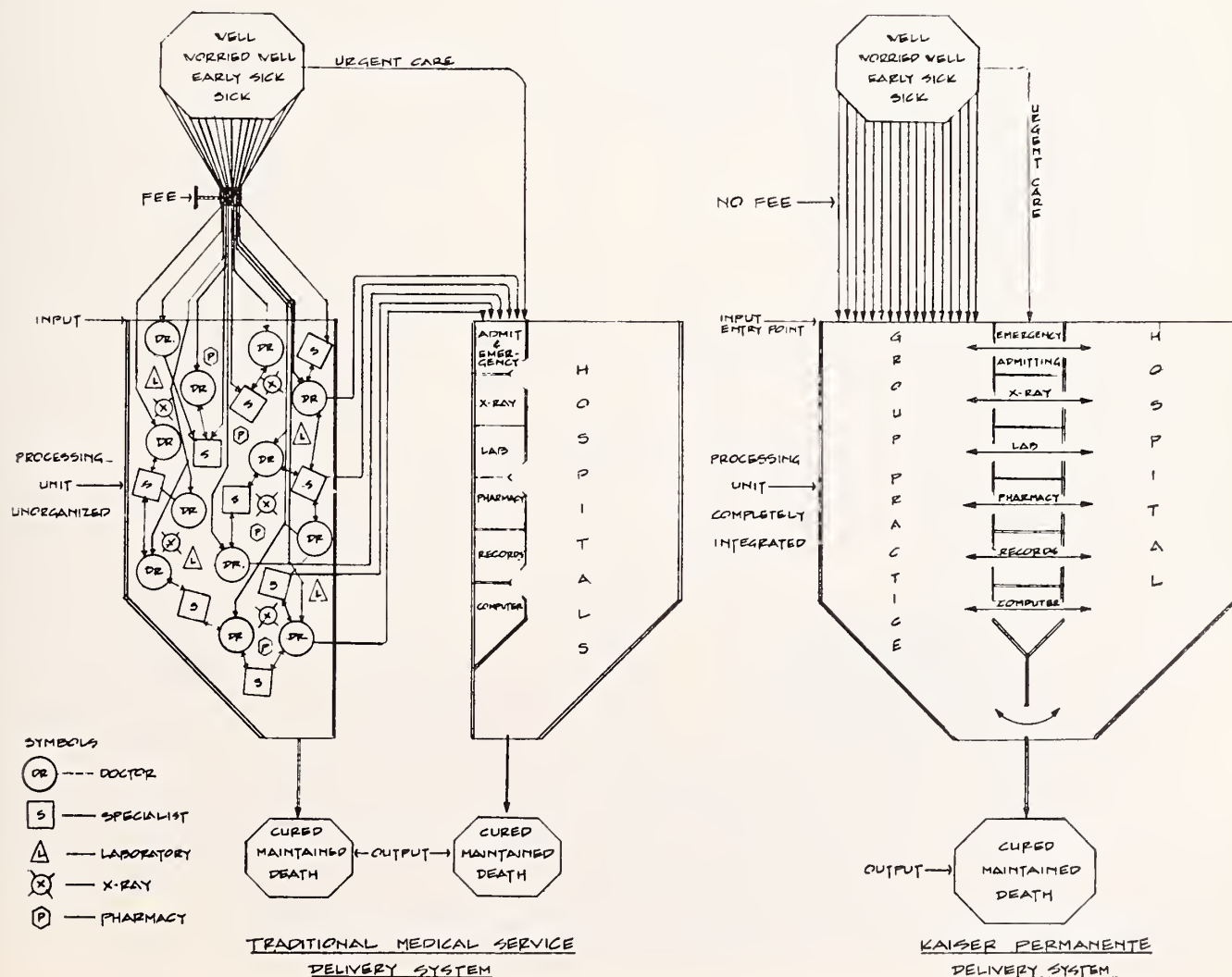
Medicaid. This floods the system not only with increased numbers of people but with that same altered entry mix containing a large proportion of relatively well people. For this considerable segment of patients the old methods of work-up by the physician become very inefficient. He spends a large portion of his time trying to find something wrong with well people, using techniques he was taught for diagnosing illness. This reverse use of sick-care technology, searching for illness in healthy people, is extremely wasteful of the doctor's time, and is, in addition, boring and frustrating for him.

This is the defect we have uncovered. The altered entry mix created by the elimination of personally paid fees, as occurs in health plans, Medicare, Medicaid

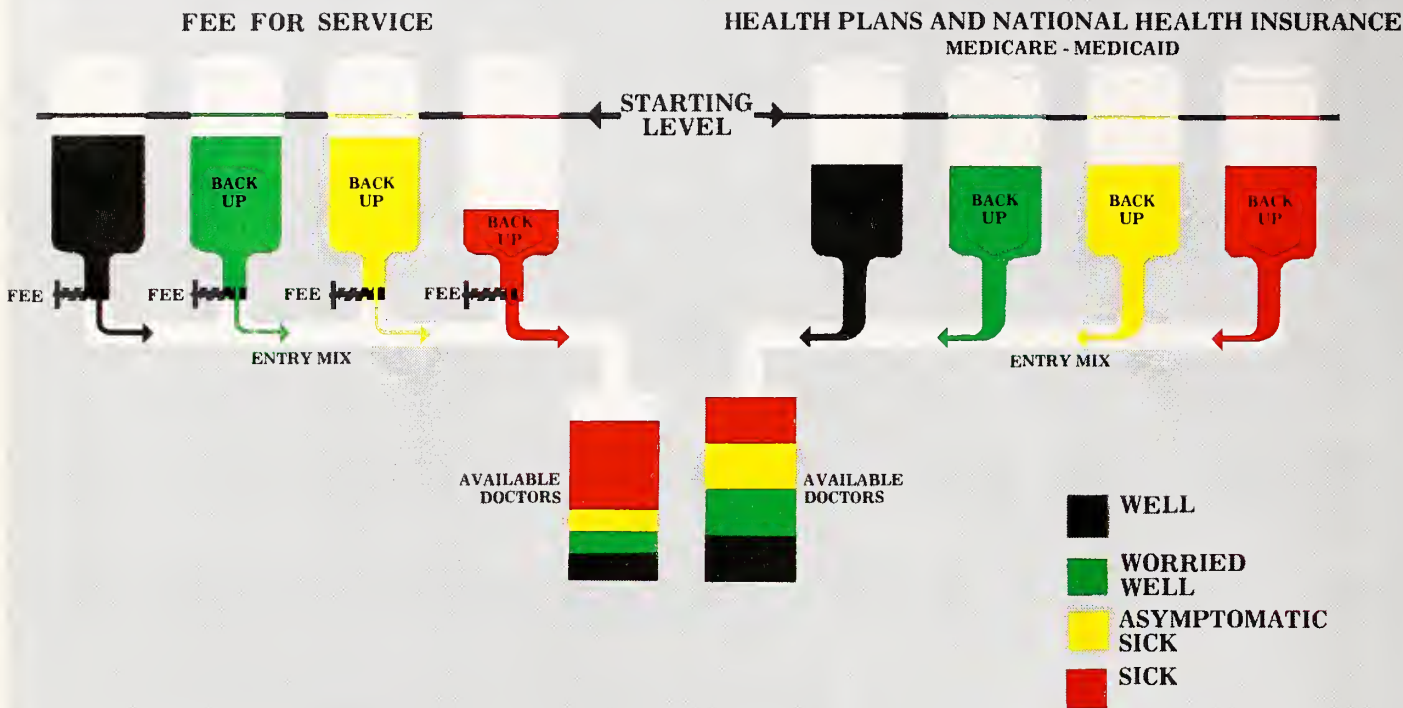
and medical care as a right, is incompatible with direct entry into today's sick-care delivery system. It is incompatible because the mismatch it creates drastically dissipates and wastes medical manpower.

Correcting this defect requires a new system design that realistically matches the altered entry mix of free care. This necessitates two things. First, a regulator of flow into the system that can separate the variable mix into its three basic components: The well, the asymptomatic sick, and the sick; and second, an adequate service to receive each of those components. The regulator we have developed is "Health Testing." The services are a new "Health-Care Service" for the well, a new "Preventive-Maintenance Service" for the asymptomatic

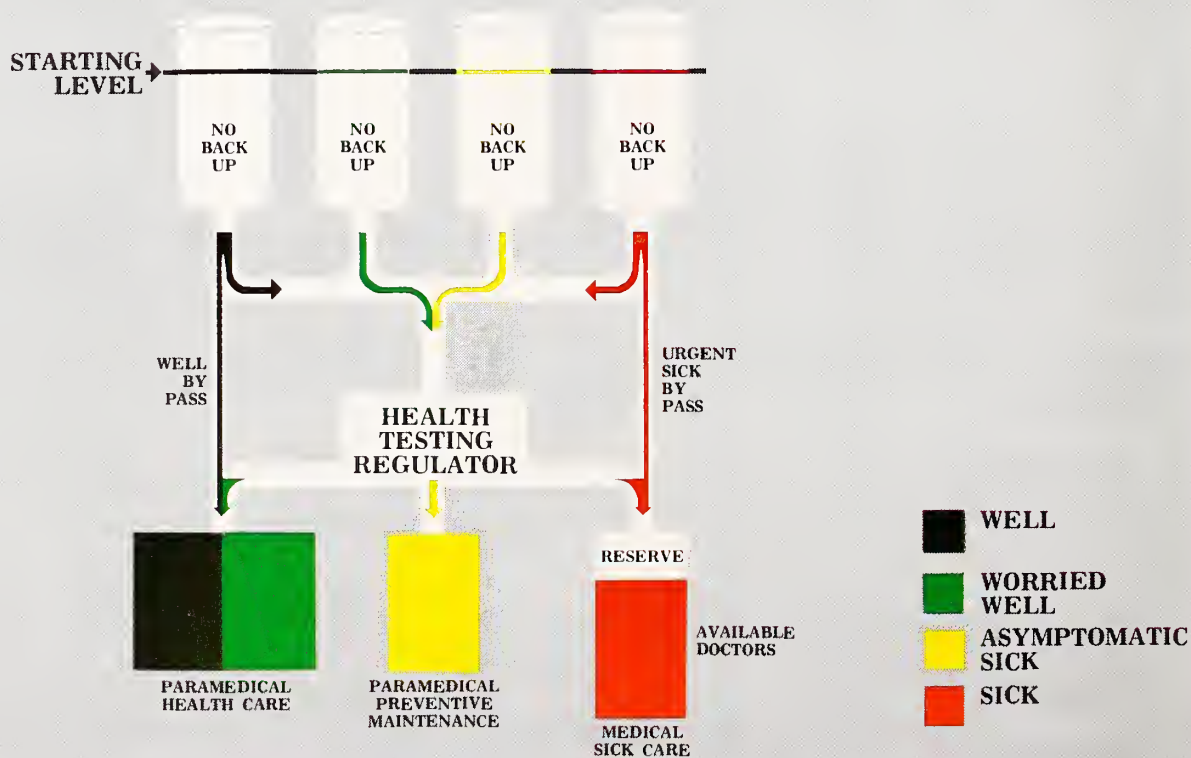
Figure 1







### NEW DELIVERY SYSTEM ENTRY METHOD



S. R. GARFIELD, M. D.

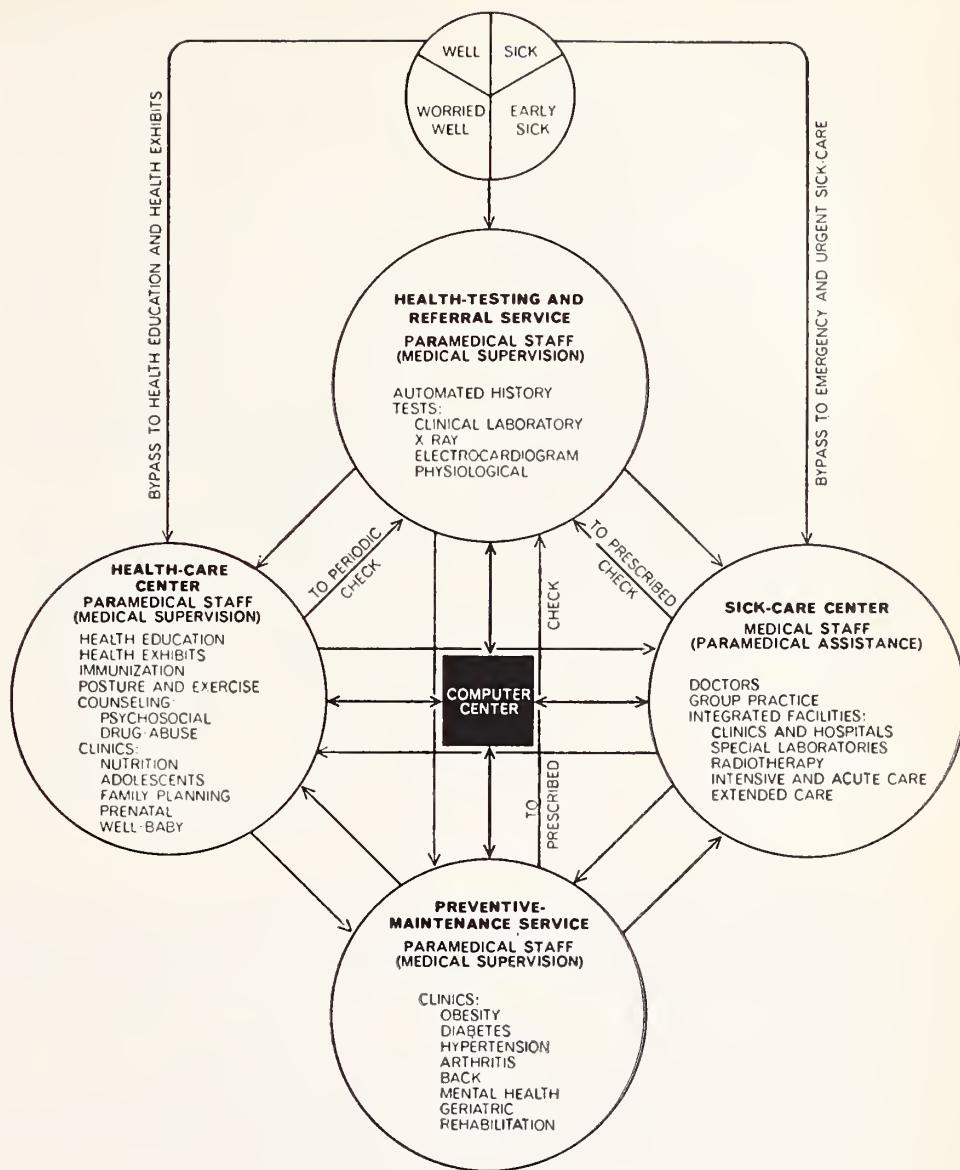


matic sick, and a pure "Sick-Care Service" for the sick.

The new system thus has four divisions (Figure 3):

1. **Multiphasic Health Testing**—the heart of the new system combines a detailed automated medical history with comprehensive panels of physiological and laboratory tests administered by paramedical personnel. Originally designed in our operations to meet the ever-increasing demand for health checkups, health testing is ideally suited as a new method of entry into medical care since it can effectively separate the entry mix into its components with a minimum of physician involvement.\*
2. **Health care** is a new division of medicine that does not exist in this country or any country. Its purpose is to improve health and keep people well. To date, health care has been an elusive concept, and understandably so, since it has been submerged in sick care—the primary concern of doctors. Doctors trained in sick care have been much too busy to be involved with well people. This clear definition of a Health-Care Service is a first step in creating a positive

Figure 3



program for keeping people well. Whether or not one believes this can be done is beside the point. This service is essential to meet the increasing demand for health care and to keep these people from using up sick-care services.

3. **Preventive Maintenance** is a service for the asymptomatic sick and high-prevalence chronic illness such as hypertension and diabetes that require monitoring and surveillance. This type of care performed by paramedical personnel reporting to the patient's doctor can relieve the physician of many routine visits.

4. **Sick Care**, with its high-level decisions on diagnosis and therapy, becomes clearly the realm of the physician. Here he becomes the manager of patient care rather than the man of all work and is aided in this by all three of the other divisions.

There are several important features to be emphasized in this new delivery system:

First—It is designed specifically to match the entry mix of free care. All other existing systems, including Great Britain's, unload the entire free care entry mix into sick care and thus

\* Some readers may be concerned about costs per positive case and false positives that occur in Multiphasic Health Testing, when it is used for mass-automated screening and case-finding. These concerns are not pertinent for Health Testing used in this new fashion, as a preliminary work-up for patients requesting physician services.

In this new use we are conserving requested physician time and costs must be measured and compared with the traditional method of entry into medical care with total involvement of the doctor. False positives should occur to the same degree in either method of entry, if the work-up is equally comprehensive.



dissipate and waste medical manpower.

Second—Three of the four divisions (Health Testing, Health Care and Preventive Maintenance) are primarily automated and paramedical services of existing types. Therefore, they are relatively easy to staff and relatively inexpensive.

The use of paramedical personnel with limited knowledge and skills to relieve the physician of routine and repetitious tasks requires such tasks be clearly defined and structured. The existing delivery system with its unstructured heterogeneous entry mix is almost the exact antithesis of those requirements and, therefore, has never permitted effective and safe use of such personnel. For this reason, Health Testing and the clear separation of services, automatically defining tasks and structure, becomes the key to paramedical manpower effectiveness.

Third—This new system requires no restructuring of sick-care services. It can function with either solo practice or group practice. All we need do to sick care is remove from it the extraneous portion of the entry mix produced by free care and which did not belong there in the first place. Sick care relieved of that considerably load of well, worried well and asymptomatic sick people thus develops a greatly increased capacity for the care of the sick.

Fourth—Past medical care has been crisis-oriented and episodic with the patient entering when he believed he was ill and leaving the system when pronounced cured. This new system permits a fresh approach to that process. Health Testing and the conditions it

reveals make it possible to plan not only the immediate services needed by the patient but also to schedule returns for updating the health profile from that point. Thus, the system can now tell the patient when to enter for care. Where today all new entries into medical care are potential emergencies, since we have no foresight of the patient's condition, under this new system only visits between scheduled returns for updating are emergencies.

The medical reason for these unscheduled visits can then be diagnosed against a background of health profile rechecks—all rapidly retrievable by computer techniques. In this fashion a large segment of medical care can be continuous rather than episodic, much of illness a trend rather than a crisis, and treatment preventive rather than putting out fires.

This is the type of system that best fits medical care as a right. It should be clear that the cause of today's medical care crisis has been the inexorable spread of free care throughout our population. The effect is an expanded and altered demand that is incompatible with the existing sick care-delivery system, wasting its medical manpower and threatening the quality and economics of the service it renders.

It is grossly unfair to blame that effect on the medical profession. The delivery system functioned fairly well with fee-for-service under which it evolved. It became unbalanced and a so-called "non-system" under the impact of the poorly planned legislation of Medicare and Medicaid with its elimination of fees, and that result should not surprise anyone. Picture what would happen to air transportation if fares were eliminated and travel became a right. What chance would you have getting anyplace if you really

needed to? Even the highly automated telephone service would be staggered by removal of fees and necessary calls would become practically impossible. The change from "fee" to "free" would disrupt any system in the country, no matter how well organized, and this is particularly true of medicine with its highly personalized sick-care service.

Nevertheless, legislation is on the move and if we are to have more free care — and it appears we will — it is crucial this time that a rational delivery system be prepared for the inevitable deluge of demand, so that we can preserve the basic medical values we believe in. These values include quality of care, availability of service and reasonable economics. Morally and practically they should also include the freedom to practice individually, or in groups, as best suits the needs of the people to be served and the physicians who serve them.

Prodding physicians against their desires into group practice will result in less production and less service, not more. Prepaid group practice requires an unusual dedication to that form of service and that dedication is relatively scarce and cannot be dictated or legislated. Actually, at this point in time we need both types of practice. It is most important that we preserve freedom of choice and changes should be evolutionary, not forced.

Viewed from our long experience with medical care as a right, the organization of practice is not the issue anyway. Neither solo practice nor group practice will function efficiently and without great waste of medical manpower until the delivery system matches the altered input of free care. This requires the missing services of Health Testing, Health Care and Preventive Maintenance. Without them the demand of free care can only deteriorate services for all and quality care as a right becomes impossible.

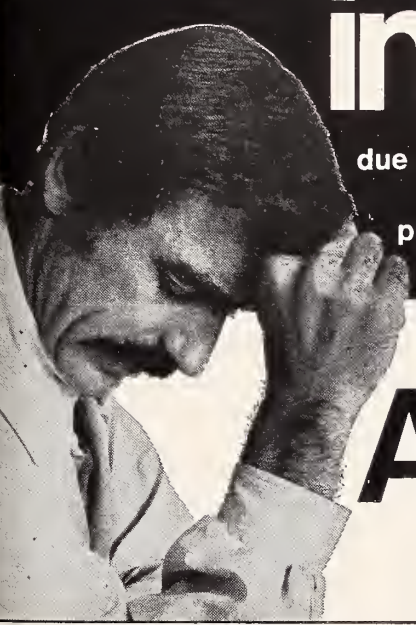


As for the major legislative proposals to date, these seem to be strangely paradoxical. They would exponentially increase demand and at the same time, through mistaken emphasis on forcing group practice, might decrease productivity. They would massively flood the delivery system by eliminating fees and at the same time destroy incentives to serve by capitation, salaries and limiting budgets. They would force an unconscionable load of well and sick on the medical profession and at the same time destroy their morale by taking away their freedom of choice on their methods of practice. A truly questionable design for the future delivery system and certainly one that is unlikely to preserve our medical values.

If there is validity in these arguments, American medicine should back medical care as a right, with the provision that it be carefully planned to preserve basic medical values. This means advocating a two-to-three-year period of preparation during which those essential paramedical services would be established throughout the country, prior to making free care effective. Hopefully, this would be done by our medical societies, with financing by some such mechanism as the \$800 million Resource Development Fund being proposed to stimulate group practice. A similar fund to establish these paramedical services would be extremely effective in bringing direct early improve-

ment to medical services for the people.

Medical care stands at a critical point. One path is legislation that with minor variations compounds the errors of Medicare and Medicaid and can only depreciate the quality and availability of care for both the sick and well. The better route is to create a new delivery system that recognizes free care is not just sick care but encompasses the entire spectrum of health. A system that, by matching that spectrum, will make it genuinely possible to achieve the principle of quality medical care as a right and preserve the best of our present medical values. That choice is our opportunity. ◀



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**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

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# *Trichomonas Cystitis in a Six-Week-Old Infant— Effective Treatment with Oral Metronidazole*

ALLEN B. SOKOL, M.D.\*

DAVID S. MIN, M.D.\*  
Hammond

*Trichomonas vaginalis* has long been recognized as a common inhabitant of the human vagina<sup>1</sup> and may be frequently encountered in the average gynecologic practice, particularly in pregnant women. *Trichomonas* infection in infants and children, however, seems to be extremely rare. Standard pediatric textbooks provide inadequate information about the occurrence and treatment of *Trichomonas* infection for the pediatric practitioner. It is not mentioned by Schaffer,<sup>2</sup> for example. *Trichomonas* vaginitis (but not cystitis) is mentioned by Nelson<sup>3</sup> where the treatment advocated is metronidazole, but the oral preparation is recommended only for older girls weighing over 100 pounds. The local preparation is advocated for use in smaller girls. (This would not be applicable for urinary tract infections, however.) Holt<sup>4</sup> mentions *Trichomonas* as a cause of non-specific vaginitis "which may be seen at any age, even in infancy" but does not mention this protozoa as a cause of cystitis. The treatment recommended is the vaginal insufflation of acetarsone powder.

Around 1960, Metronidazole,\* a nitromidazole derivative, was introduced and markedly improved the treatment of trichomoniasis.<sup>1</sup> In 1962, Crowther<sup>5</sup> reported two cases of *Trichomonas* vaginitis in infants four and six weeks old, respectively. Both infants had been delivered prematurely and weighed approximately 3½ pounds at birth. One infant had a spine bifida and myelomeningocele. Both infants showed clinical signs of vaginitis (discharge) and both contained *Trichomonas* in the urinary sediment. They were successfully treated (both the urinary and vaginal infection) with oral Metronidazole without vaginal insufflation. Binder,<sup>6</sup> in 1963, reported a case of vaginal trichomoniasis in a two-month-old female infant (full term birth). She was treated unsuccessfully with a pediatric preparation containing phenylmercuric acetate, tyrothricin, hydrocortisone, and diethylstilbesterol in the form of vaginal suppositories. The infant was then treated with Metronidazole and the infection cleared within 10 days.

In 1966, Littlewood and Kohler<sup>7</sup> reported a urinary tract infection due to *Trichomonas vaginalis* in a premature baby (birth weight 3 lb. 3 oz.) in whom there

was no clinical evidence of vaginitis. The onset of symptoms was on the 19th day and was manifested by distention of the abdomen and the veins of the abdominal wall together with enlargement of both kidneys. Urinalysis revealed a pyuria due to "moderately numerous bacteria" and *Trichomonas vaginalis*. Urine culture obtained a mixed growth of a coliform bacillus and *Staphylococcus aureus* and *albus*. Further examinations of the urine were carried out between the 19th and 63rd days on 10 occasions and *Trichomonas* were demonstrated on all except one occasion. On the 64th day oral Metronidazole therapy was begun. This was followed by a rapid disappearance of the parasite and a decrease of the white cells in the urine to within normal limits.

This 1½ month old female infant developed a fever of 101-102°F and vomiting one day prior to admission. On the day of admission, her vomiting and fever had worsened. Aside from the fever and a mild to moderate dehydration, the physical examination was unremarkable.

Previous history revealed a spontaneous delivery of a premature infant of 7½ months gestation. The birth weight was 3 lbs. 15 oz. The infant arrived in the newborn nursery with grunting respirations, inter-

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\* Metronidazole: Flagyl (G. D. Searle and Co., Chicago, Ill.).



costal retractions, cyanosis and generalized hypotonia. The admission pH (warm-heel, arterialized blood) was 7.32. The blood sugar was normal. The infant was treated with intravenous sodium bicarbonate and glucose solution, oxygen, and supportive therapy. She made an uneventful recovery except for a subsequent hyperbilirubinemia which was rather easily managed with phototherapy and hydration. The infant was discharged weighing 5 lbs. 4 oz. and doing well with a Hb. of 11.2 gms %. There were no further problems until the onset of the present illness.

The initial blood count revealed a leukocyte count of 5,000/cu mm with 85% lymphs and 15% neutrophils. The hemoglobin was 8.6 gms %. Blood urea nitrogen, creatinine, and serum electrolytes were normal. The initial clean, voided urine specimen revealed negative protein, sugar and acetone but 25-30 WBC/HPF with occasional clumps and *Trichomonas vaginalis*. A catheterized urine specimen revealed 15-20 WBC/HPF, 3+ bacteria, and 3-4 *Trichomonas* per field. The colony count was over 500,000 bacteria/ml. A *Klebsiella* species was cultured. The patient was treated with sulfasoxazole\* pediatric suspension which brought the fever down and decreased the number of WBCs in the sediment the next day, but the *Trichomonas* infection persisted. The following day the patient was placed on an oral suspension of metronidazole, 20 mg three times a day, and the urine was cleared of *Trichomonas* three days later. The treatment was continued for a total of seven days. Intravenous pyelography revealed a normal collecting system with rapid excretion of the dye and no evidence of hydronephrosis. The bladder had a normal outline. A blood trans-

fusion was given. The patient was discharged doing well with a Hb of 12.7 gms %. Subsequent examinations of the urine one week and one month later were normal. Repeat blood counts were normal and the infant showed no adverse effects from the drug.

### Discussion

The incidence of Trichomonal infection in infants under one year of age appears to be very low. Isolated cases of vaginitis in infants have been reported by Brady and Reid<sup>8</sup> and by Karnaky.<sup>9</sup> Trussell and Wilson<sup>10</sup> in 1942 made an effort to determine if female infants might be infected by their mothers during birth. Forty-one babies of infected mothers were examined within the first eight days. Only two babies were found to be infected (approximately 5%). A subsequent study in 1960 by Coronel and Lillo<sup>14</sup> confirmed these figures. They identified this organism in the vagina of 6.6% of newborn infants delivered of mothers who had been identified as having antepartum infections. Of the 110 cases of puerperal vaginitis reported by Lang,<sup>12</sup> only 4 had Trichomonal infections and none of these was under one year of age.

While the incidence of Trichomonal infection as a cause of vaginitis in infants may be low, this organism as a possible etiologic agent should not be ignored. Kamorowska et al.,<sup>13</sup> for example, found that 6 of 35 female infants less than 3 weeks old who had a vaginal discharge were infected with *Trichomonas*. In addition, it now appears that the urine should be checked for this organism in all infants found to be infected with *Trichomonas*. Although this is not difficult (the organism is apparently readily identified in the routine microscopic urine exam which makes an effective "hanging-drop" prepar-

ation) when there is an associated vaginal infection, a catheterized specimen is necessary to confirm the diagnosis of a urinary infection. The contamination by vaginal secretions of non-catheterized specimens of urine is well known in adults<sup>6</sup> and children. If necessary, the organism can be cultivated on Kupferberg simplified tripticase serum medium.<sup>1</sup>

This report, however, represents the second case of a urinary tract infection by *Trichomonas* without clinical evidence of vaginitis. It was associated with a secondary infection of the urinary tract. As indicated by this case and the previously cited cases,<sup>5,7</sup> unless the *Trichomonas* is specifically treated, the urinary infection will not clear up. Thus, in any acute or chronic urinary infection that does not respond to the usual or specific antibiotic therapy and is not explained by obstruction, abnormal communication, resistant organisms, etc., a search should be made for *Trichomonas*.

The origin of these infections is not altogether clear. Most authors are inclined to believe that the source of these infections is from the mother, in spite of the fact that it is frequently not possible to demonstrate such an infection. Crowther, for example, was not able to demonstrate a maternal infection in his first case when the examination was done after the discovery of the infection in the infant. In the second case there was evidence that the mother had been treated for a Trichomonal infection in the "lying-in period."<sup>5</sup> Littlewood and Kohler found no evidence of a Trichomonal infection in the mother's clinical record and a later examination (at the time of the infant's infection) was negative.<sup>7</sup> In the case reported by Binder, the mother had been treated for vaginitis during the pregnancy, but the nature of the vaginitis was unknown.<sup>6</sup> In our own case, one of us (D.M.) had followed the mother during her pregnancy with-

\* Sulfasoxazole: Gantrisin (Roche Laboratories, Nutley, N.J.)



out any clinical evidence of vaginitis. A check for *Trichomonas* after the diagnosis was made in the infant was negative.

Prior to Metronidazole, the oral treatment for *Trichomonas* infection was not particularly effective.<sup>11</sup> Local therapy (vaginal inserts, insufflation, water-miscible jellies) also left a lot to be desired.<sup>14</sup> It would appear that at the present time the most effective treatment for both vaginal and urinary infection in infants and children is oral Metronidazole.

### Summary

(1) A case of a urinary tract infection in a 1½-month-old infant due to *Trichomonas* is presented. There was no clinical evidence of vaginitis. This is the second such case reported.

(2) It is of interest that four of the five infants with clinical *Trichomonas* vaginitis and/or cystitis reported recently in the English literature were premature.

(3) In a urinary infection in infancy that is persistent or does not respond to the usually effective antibiotic therapy, a search should be made for *Trichomonas*.

(4) In all cases of *Trichomonas* va-

ginitis in infancy, the urine should be checked for an associated *Trichomonas* urinary infection.

(5) The evidence from these reported cases would suggest that the treatment of choice for both *Trichomonas* vaginitis and cystitis in infants is oral Metronidazole.

### Acknowledgment

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# Diagnosis and Treatment of Bacterial Endocarditis

JACKSON G. CROWDER, M.D.  
Indianapolis

**B**ACTERIAL endocarditis, almost uniformly fatal in the pre-antibiotic era, is now curable in the majority of cases. Early diagnosis is essential for cure. Therefore, physicians must have a high index of suspicion for endocarditis, despite the fact that the average physician sees it uncommonly.

Viridans streptococci are still the most common organisms causing endocarditis.<sup>1,2</sup> However, the proportion of cases due to enterococci, staphylococci and gram-negative enteric bacteria has increased.

## Clinical Findings

The two most constant findings in endocarditis are fever and a heart murmur. In *Streptococcus viridans* endocarditis, temperature is usually less than 103 F and may have been present for weeks or months. By contrast, a more septic course with higher temperatures is found in endocarditis due to pyogenic organisms such as staphylococci.

Most patients have a cardiac murmur, produced by underlying rheumatic or congenital heart disease or by endocarditis itself. However, absence of a murmur early in the course should not deter the physician from considering endocarditis.

Other physical findings associated with infection or peripheral emboli are less frequent but should be sought. These include splenomegaly,

clubbing, conjunctival or retinal hemorrhages, sub-ungual hemorrhages, and neurological abnormalities. Osler nodes, tender erythematous lesions on the hands and feet, are helpful when present. However, in our experience, Osler nodes and Janeway lesions are observed in less than five percent of patients.

Blood counts commonly reveal anemia. Leukocytosis occurs in approximately half the patients, and a normal white count should not mislead one into ruling out endocarditis. Proteinuria and microhematuria occur as manifestations of the glomerulitis accompanying endocarditis. Hyperglobulinemia and positive tests for rheumatoid factor occur in about half the patients.

## Diagnosis

Endocarditis should be considered in any patient with fever and a murmur, whether evidence of peripheral emboli is present or not. The most important test in confirming the diagnosis is the blood culture. Generally, six blood cultures obtained over a 24 to 48 hour period are sufficient. However, therapy should not be delayed if endocarditis due to staphylococci or other pyogenic organisms is suspected. Cultures should be obtained over several hours and therapy initiated.

Blood should be cultured anaerobically, as well as aerobically, since as many as 16% of cases are caused by organisms requiring reduced oxygen tension.<sup>1</sup>

## Treatment

It is important to use bactericidal antibiotics. Use of bacteriostatic antibiotics has been associated with high relapse rates. The laboratory should perform tube dilution sensitivity studies to determine more precisely the sensitivity of the infecting organism. In addition, once therapy is begun, the antibiotic activity in the patient's serum should be assayed against the causative organism. Sufficient antibiotic should be given so that the patient's serum is bactericidal for his organism in a 1:8 or greater dilution of serum during most of treatment.

Most *Streptococcus viridans* are highly sensitive to penicillin G, requiring 0.2 micrograms per milliliter or less for inhibition. Four to six million units of penicillin G daily by intravenous or intramuscular routes for three to four weeks is adequate.

It is important to differentiate *Streptococcus viridans* from enterococci, because enterococci are only moderately sensitive to penicillin. Although all *Streptococcus viridans* are alpha hemolytic, some enterococci also give alpha hemolysis on blood agar. It should not be assumed that an alpha hemolytic streptococcus causing endocarditis is *Streptococcus viridans* until appropriate laboratory procedures have excluded that the organisms are enterococci.

Twenty million units of penicillin daily is given intravenously for endocarditis due to enterococci and

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*Streptococcus viridans* not highly sensitive to penicillin. Streptomycin is added since synergism has been demonstrated between penicillin and streptomycin in treatment of enterococcal endocarditis. Penicillin is administered for six weeks and streptomycin for three to four weeks.

Patients with a clinical picture of endocarditis but negative blood cultures constitute 5 to 20% of cases in various studies. These patients should be treated as if they had enterococcal endocarditis.

Staphylococcal endocarditis can be treated with either methicillin (Staphcillin) or cephalothin (Keflin) in dosages of 12 to 16 grams daily for six weeks. If the organism is proved sensitive to penicillin G, 20 million units of penicillin daily is adequate.

In treatment of patients allergic to penicillin or cephalothin, or in treatment of endocarditis due to methicillin-resistant staphylococci, vancomycin (Vancocin) is the drug of choice.

Patients should be hospitalized for treatment. Development of congestive failure in endocarditis is associated with a high mortality with medical treatment alone. Facilities for emergency replacement of damaged valves should be available.

## Endocarditis in Heroin Addicts

Right-sided endocarditis is more frequent in heroin addicts. All addicts with endocarditis seen in our hospitals over the past two years have had tricuspid involvement. Manifestations are predominantly pulmonary, produced by septic emboli to the lungs. Although the incidence of pneumonia without endocarditis is higher in addicts as compared to non-addicts, right-sided endocarditis should be suspected in any addict who presents with pulmonary infiltrates, particularly if infiltrates develop sequentially.

Unlike endocarditis in non-addicts, penicillin-sensitive organisms such as viridans streptococci are uncommonly found. Staphylococci and gram-negative bacilli are usually isolated. For this reason, we initiate treatment with methicillin or cephalothin plus gentamicin (Garamycin) for gram-negative coverage.

## Endocarditis on Prosthetic Valves

Endocarditis on prosthetic valves is caused by a variety of organisms, including staphylococci, streptococci, gram-negative bacilli, diphtheroids and fungi. Organisms considered non-pathogenic — such as

*Staphylococcus epidermidis* and diphtheroids — may produce endocarditis in these patients, and when isolated from blood should not be dismissed as contaminants.

Prosthetic valve endocarditis has been caused by fungi, most commonly *Candida* and *Aspergillus*. Fungal endocarditis is notable because of large valvular vegetations. Hence, patients with endocarditis and emboli to large arteries should be suspected of having fungal endocarditis.

Most of the organisms causing prosthetic valve endocarditis are resistant to penicillin. Antibiotics are administered as determined by *in vitro* sensitivity tests. Despite antibiotic treatment, however, the prosthetic valve frequently must be replaced.

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### **1.2 to 8 grams/day IV dosage range:**

Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections.

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In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

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infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

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In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

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Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonic treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rash, urticaria, vaginitis, and rare instances of foliaceous and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distilled water or normal saline has produced local irritation or phlebitis.

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## Use of Approved Drugs for Unapproved Uses

The Food and Drug Administra-  
tion recently published proposed  
regulations on the use of approved  
drugs for unapproved purposes. As  
is customary for proposed regula-  
tions, comments by interested phy-  
sicians were invited. Such comments  
must be mailed before October 15.

The subject is a serious one. For  
several years officials within the  
FDA have made statements to the  
effect that malpractice suits based  
on the use of drugs in any manner  
or for any indication not specified  
and approved by the FDA would be  
difficult to defend. These statements  
have never been counteracted or  
denied.

The present proposed regulations  
would seem to be an attempt to  
clarify the matter to allay the im-  
pression that the FDA was prepared  
to dictate to the profession the man-  
ner of managing drug therapy.  
Whether the regulations do this or  
not is a matter of interpretation.

FDA Commissioner Charles C.  
Edwards states that the purpose of  
the regulations is to "make it clear  
that we're not in the practice of  
medicine and have no intention of  
being there, at least not as long as  
I'm here."

In the words of the "Notice of  
Proposed Rule Making" — "Ac-

cordingly, the Commissioner pro-  
poses to add a new regulation clari-  
fying the applicable legal require-  
ments and specifying actions that  
may be taken by the Food and Drug  
Administration with respect to un-  
approved uses of approved prescrip-  
tion drugs."

After explaining what labeling  
may legally do, the following state-  
ment would seem to specify what it  
cannot do. "Once the new drug is  
at a local pharmacy after interstate  
shipment, the physician may, as part  
of the practice of medicine, lawfully  
prescribe a different dosage for his  
patient, or may otherwise vary the  
conditions of use from those ap-  
proved in the package insert, with-  
out informing or obtaining the ap-  
proval of the Food and Drug Ad-  
ministration."

Later the "Notice" states: "Al-  
though the Act does not require a  
physician to file an investigational  
new drug plan before prescribing an  
approved drug for unapproved uses,  
or to submit to the Food and Drug  
Administration data concerning the  
therapeutic results and the adverse  
reactions obtained, it is sometimes  
in the best interest of the physician  
and the public that this be done."

Following this "reassuring" lan-  
guage the remainder of the proposed  
regulation outlines possible actions  
in the event that the unapproved  
use of an approved drug becomes

widespread, summarized as follows:

Additional warnings or contrain-  
dications in package inserts may be  
required.

Manufacturers may be required  
to prove efficacy in the unapproved  
use.

Prescription refills may be lim-  
ited.

Distribution channels may be lim-  
ited to a specified few, such as  
hospital pharmacies.

Prescribers may be limited to  
physicians with *specified qualifica-  
tions*.

The drug's approval may be re-  
voked.

Written comments on the pro-  
posed regulations are requested and  
should be submitted by physicians  
who are interested. This should be  
done promptly to avoid the October  
15 deadline. A copy of the com-  
ments should be sent to the doctor's  
Congressman.

The full text of the proposed reg-  
ulation, containing instructions for  
the comments, is reproduced below.

§ 130.---- Legal status of labeling,  
including package inserts and  
product brochures, for pre-  
scription drugs; prescribing  
for uses unapproved by the  
Food and Drug Administra-  
tion.

(a) The Food and Drug Admin-



istration approves labeling for a prescription new drug as part of the new drug approval process. Supplemental new drug applications may periodically result in revision of the labeling.

(1) The labeling approved by the Food and Drug Administration in a prescription new drug application summarizes all information with respect to the conditions of use for which substantial evidence is available to the Food and Drug Administration that the drug is safe and effective.

(2) A prescription new drug may not be shipped in interstate commerce when intended for uses not contained in the currently approved labeling. Such unapproved uses may include, inter alia, a different dosage, or a different patient population, or a different regimen, than that approved. Section 505 of the Federal Food, Drug, and Cosmetic Act requires that a manufacturer, physician, or other person who ships or requests shipment of a prescription new drug in interstate commerce with the intent, or for the purpose, of an unapproved use must first file with the Food and Drug Administration an investigational new drug plan as set out in §130.3.

(3) Once a prescription new drug has been shipped in interstate commerce intended for its approved use(s) under approved labeling, the Federal Food, Drug, and Cosmetic Act does not require a physician to file with the Food and Drug Administration an investigational new drug plan in order to lawfully prescribe the drug for an unapproved use, when such prescribing is done as part of the practice of medicine.

(b) When an unapproved use of a new drug may endanger patients or create a public health hazard, or provide a benefit to patients or to the public health, the Food and Drug Administration is obligated to take one or more of the following

courses of action:

(1) Revision of the package insert may be required to add a specific contraindication or warning against the unapproved use.

(2) The manufacturer may be required to obtain and submit the available data with respect to the unapproved use, or to sponsor clinical trials to determine the safety and effectiveness of the drug for the unapproved use.

(3) If substantial evidence of safety and effectiveness is available, revision of the package insert may be permitted or required to add the unapproved use as an approved use and to state the conditions under which the drug is safe and effective for that use.

(4) Revision of the package insert may be required to state that a prescription for the drug should not be refilled.

(5) Revision of the package insert may be required to state that the drug should be distributed only through specified channels (e.g., hospital pharmacies) and/or should be prescribed dispensed, or administered only by physicians with specified qualifications.

(6) The investigational new drug authority, as well as the new drug approval authority, may be invoked to impose a requirement that the drug may be distributed only through specified channels and/or may be prescribed, dispensed, or administered only by physicians with specified qualifications.

(7) The package of the drug dispensed to the patient may be required to contain a package insert containing appropriate information for the safe and effective use of the drug by the layman.

(8) The approval of the new drug application may be revoked.

Interested persons may, within 60 days after publication hereof in the FEDERAL REGISTER, file with the Hearing Clerk, Department of

Health, Education, and Welfare, Room 6-38, 5600 Fishers Lane, Rockville, Md. 20852, written comments (preferably in quintuplicate) regarding this proposal. Comments may be accompanied by a memorandum or brief in support thereof. Received comments may be seen in the above office during working hours, Monday through Friday.

Dated: July 30, 1972.

CHARLES C. EDWARDS,

*Commissioner of Food and Drugs.*  
[FR Doc.72-12812 Filed 8-14-72; 8:45 am]

## Guest Editorials

### Nobody Votes in My Town

AS another presidential election day approaches, probably never before was so much at stake in America. But nobody votes in my town and most of my 3,700 townsmen apparently are chronic misfits who couldn't care less. My town is "Jacktown"—Southern Michigan Prison, near Jackson.

Now, in the morning chow line, a young murderer and a middle-aged burglar seem ready to tangle in an argument on the merits of the Republican Party. An alert guard breaks it up just in time.

The burglar is serving his fifth term in my town. I know him well. So, after he cools off, I needle him a bit, saying, "I take it you voted for Hubert Humphrey."

"You kiddin'?" he scowls. "Man, I never voted in my life. I got sense enough to know no matter who gets elected, the best any little guy's gonna get is the worst of it. The hell with votin'!"

That's seditious philosophy, isn't it? "The hell with votin'!" Means down with democracy, your country, your government and, consequently, every home (where Government really begins) in the land.

Yet, I have been guilty of com-



parable "sedition." It came out disguised something like this: "Didn't get around to voting; had too many other things to do on election day." The reflection isn't easy to face, now that I have been stripped of my voting rights for many elections to come.

I begin to wonder how my neighbors feel about not being allowed to vote. Later, I question nearly 300 of them. Almost 90% merely shrug or otherwise indicate lack of concern. Eighty individuals admit that they had never voted! (Could the deeds that landed us here be germane to such disregard for democracy?) Consider three responses to: "Did you vote regularly when you were free?"

Gambling syndicate underling (age 33, serving 5-10 years): "The organization always saw to it that I voted; even told me who and what to vote for."

Alcoholic (age 47, doing 1-2 for non-support): "They'd let me off work in time to make it to the polls, all right. But I'd stop at a buddy's house to talk the election over. There'd be a bottle or two around. And somehow, before I considered all the issues and candidates and decided who'd get my vote, it was either too late or I was too loaded to care anymore."

Sex offender (age 39, serving 1½-10 years): "I never voted except in presidential elections. I voted for Dick (because my name is Nixon, too)." (Wouldn't it be interesting to know how many other votes are cast for similar, lackadaisical reasons?)

As for me—well, occasionally it is unpleasant to face the mirror of patriotism. Instead of voting I have gone hunting and fishing, attended to personal matters of assorted kinds. But the future will offer opportunities to prove my determination never again to skip a chance to vote. And I will vote as intelligently as I can.

In the meantime, what about you?

Like many other sheer blessings in our full-fashioned freedom, the privilege of voting just can't completely be appreciated until it is lost. I know. So I must agree with the immigrant who said: "Most Americans can't adequately appreciate their system of government because they don't understand what it ain't."

However, our Star Spangled Banner waves best when every thread is intact. Similarly, the government it represents needs every vote.

But nobody votes in my town. Nobody may.

What could be worse, patriotically?

Your town, where every adult citizen may vote . . . and you don't.

—Pete 87776 Simer.

### Development of Community Emergency Medical Services Councils

SO many people assume today that high quality emergency care is generally available. There is a general belief that *surely* some arm of government has acted to insure that it is. Sleek, shiny ambulances with authoritative flashing lights and wailing sirens manned by white-coated attendants give credence to such belief. The facts are quite to the contrary. The quality and ready availability of emergency care services vary widely from one locality to another, but in most localities care is not so readily available and in many the quality of the care is likely to be primitive. Unbelievably, in some communities no pretense of any kind is made that any kind of first aid or personal care is given at all. In such places, ambulances are considered to be solely a means of transporting the victim from one place to another. — Paul V. Joliet, M.D., Health Officer Washington County Health Dept., Hagerstown, Md.

### Federal Ranking of Drugs Questioned

CONCERNED that the U. S. Food and Drug Administration is moving in the direction of assuming powers to judge the *relative* efficacy of various drugs, the Pharmaceutical Manufacturers Association has written the FDA calling attention to the implications of such a development.

PMA stressed that it is not concerned about the practice of rating drugs as such—noting that such data may assist the physician, not merely in choosing a given drug, but also in selecting from alternative classes of compounds of possible value to the patient. The distinction lies in the source of the ranking, PMA said. When the government does the ranking, a question must be raised about the legal position of the physician who elects to disagree on the basis of his own clinical experience, or for other reasons.

At the American Medical Association's 1972 annual meeting, the House of Delegates adopted a resolution opposing government determination of relative efficacy. "There are few drugs which can categorically be considered the drug of choice for a particular indication in *all* patients," the statement said, putting AMA on record against "any proposal that would officially establish through government regulation a classification of drugs of choice for any particular medical indication."

AMA had earlier taken the position that the package insert is "not a legal restriction on the thoughtful and careful use of a drug by an informed physician." It should be noted, nevertheless, that physicians are increasingly being subjected to malpractice actions based at least in part upon their alleged failure to adhere to the restrictions contained in FDA-approved labeling.



There appear to be several reasons for the desire of some FDA personnel to introduce relative efficacy ranking, one of the key ones being concern about the number of competing drug products. For example, an unidentified FDA expert was quoted in the *Washington Post* to the effect that "we need another diuretic like a hole in the head." Clearly, if the drugs of choice in each therapeutic class could be determined in an absolute sense, then the need for alternates would be greatly reduced. Leaving aside the question of whether FDA is supposed to discourage competition among pharmaceutical houses, PMA points out that "it is not uncommon to find authoritative disagreements as to the drugs of first choice (or second and third for that matter)." Using the therapy of gonorrhea as an example, PMA notes that not only is there no consensus as to the ranking of alternatives to penicillin G, "there is not agreement as to what the alternatives are."—**National Pharmaceutical News, July 1972.**

## Editorial Notes . . .

**Veterans with discharges "other than honorable" because of drug use or possession may apply for a discharge review.** The policy has been in force for several months. The VA is prohibited by law from treating veterans with dishonorable discharges. The Department of Defense is anxious to reclassify discharges issued 'under other than honorable conditions' solely on the basis of personal use of drugs or possession of drugs for such use, in order to make such veterans eligible for VA drug treatment centers.

**Research on the barbershop floor is the rule of the day at Purdue.** Contamination of air and water with cadmium is being contrasted be-

tween the industrial area of Lake and Porter Counties and the relatively rural environment in Lafayette. Hair clippings are being collected for analysis, and autopsy findings, including cadmium content of vital organs, will be studied in the two regions.

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### **The Veterans Administration is sponsoring a nationwide screening of black persons for hypertension.**

It has been found on preliminary study that between the ages of 25 to 44 years, high blood pressure kills 15.5 times as many black males as white, and 17 times as many black females.

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**Suit was brought against the FDA, under the freedom of information act, for disclosure of all clinical and toxicological tests data on safety and efficacy submitted with New Drug Applications for eight oral contraceptives.** A court has ruled that such test data are trade secrets and are confidential under the law. On appeal, the Pharmaceutical Manufacturers Association has supported the FDA position and has petitioned the U. S. appeals court to uphold the lower court opinion.

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**Population growth in Indiana from 1967 to 1972 was exactly the same as that for the nation as a whole—5.5%.** Changes ranged all the way from minus 6.8% for the District of Columbia to plus 15.6% for Florida, and 15.4%-up for Nevada. The grand total for the U. S. at the end of 1971 was 208,170,000. The annual increase for the nation in 1971 was 0.99%, slightly below 1.10% and 1.05% for 1970 and 1969.

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**New and elevated production standards for certain types of vaccine resulted in discontinuance of**

**several vaccines which had limited use patterns.** Both Merck, Sharpe & Dohme and Merrell-National Laboratories announced in April that some of their vaccines were being discontinued because the cost of providing effectiveness data would have been overwhelming. The FDA announced cancellation of production licenses on these vaccines. The FDA announcement was made three months after the manufacturers stopped making the vaccines. No reason was given for the FDA announcement nor for its tardiness. Both Merck and Merrell have issued statements to the effect that production of vaccines, blood fractions and other biologicals, except for the discontinued lines, continues as previously.

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**Giving heroin to addicts through large clinics as a means of eliminating the crimes by which addicts support their habit would not work, according to Dr. Vincent Dole, an advocate of methadone clinics.** Reasons are that, contrary to methadone, heroin dosage must be increased with passage of time, it must be administered at least three times daily, and does not allow any rehabilitation back to normal living patterns. While methadone is addicting, it allows a stable dosage with few clinic visits and with recovery sufficient to allow a return to normal jobs.

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**The Pharmaceutical Manufacturers Association opposes the use of a federal drug formulary in government health programs.** PMA President C. Joseph Stetler recently observed that, while the formulary system is favored because of expected economies, the exact opposite has occurred in many states in the medicare operation. The state medical programs with restrictive formularies are almost always as



sociated with high administrative costs.

**Emotions Anonymous has been formed by a group of individuals who have found emotional health by adopting the technics of Alcoholics Anonymous.** The founders were formerly members of Neurotics Anonymous but have split off because of emotional differences between the two organizations.

**Physicians fees increased by 1.37% during the first nine months of the Economic Stabilization Program.** During the same time the Consumer Price Index rose 2.05%. The Physicians Fee Index was up by 4.38% during the nine months before stabilization. The Semi-Private Hospital Room Index increased by 3.84% under controls, as contrasted to 6.62% the previous eight months.

**For several years the status of major drug reactions has been illustrated by the quotation that annually 1.5 million hospital admissions in the U.S. are because of drug reactions.** This originated in a Johns Hopkins report in 1969 and was the result of a three-month tally of 714 admissions to the wards. Extrapolation of this small series to the entire U. S. produces the 1.5 million figure. It has been repeated frequently, presumably because it is sensational. Actually a survey of five large Philadelphia hospitals shows that, of 86,100 admissions, the drug reaction percentage was 0.49 for one year and 0.41 the second year, a much less sensational proportion and one that is more credible, and more in line with common clinical experience.

**The AMA and the National Board of Medical Examiners have a thing on certification of physi-**

**cians' assistants.** The joint project will determine the best way to create certifying examinations that will ensure the orderly development of the concept of the assistant to the primary care physician.

**Licensed physicians to the number of 12,257 were added to the U.S. medical profession in 1971.** This is an 11% increase, the largest ever for one year. More than a third of these, 4314 to be exact, were graduates of foreign medical schools. Indiana was one of 13 states which issued between 200 and 400 licenses in 1971.

**A gene with a known function has been transferred to a mammalian cell in vitro.** Work at the Roswell Park Memorial Institute, under a Hartford Foundation grant, is believed to be the first instance of gene transfer. An ultraviolet irradiated Herpes Simplex Virus was able to donate at least one of its genes to mouse cells growing in tissue culture. The mouse cells used in the experiment lacked the enzyme thymidine kinase. The virus-transformed cells did not produce infectious Herpes virus but synthesized the enzyme for more than a year of serial subcultivation.

**The president of the Independent Retail Druggists Association of Quebec, Canada, favors legislation to allow the pharmacist the right to choose the source of the drug when filling a prescription.** He thinks that the prescriber should not be able to insist on any certain product by simply writing "no substitution." In fact, this Canadian pharmacist thinks the law should mandate that the prescriber present valid objective criteria, written on the prescription, if he wants to specify the brand he wishes for the patient.

**A Congressman's poll of residents in the Lansing, Mich., area consisted of asking citizens to check one or more of six choices.** The replies were: 42% favored a program to meet catastrophic costs; 34% would require employers to provide health insurance for employees; 33% wanted tax credits for premiums for private insurance; 27% favored a new program to replace Medicaid; 26% voted for complete nationalization of health insurance; and 15% urged no new legislation. Total responses amounted to 17,000. More Congressmen should ask the people about their desires for health care.

**The VA is expanding its special drug treatment centers.** Twelve new centers will be opened soon and six of the 32 existing VA centers will be expanded. Some 20,000 veteran drug addicts were treated by VA in fiscal year 1972 — compared to 5000 the previous year.

**Father Flanagan's Boys' Home, of Boys Town, Nebraska, has established a Boys Town Institute for the Study and Treatment of Hearing and Speech Disorders in Children.** The \$30 million Institute will operate two facilities, one on the Boys Town campus, and the other a part of the Criss Institute for Health at Creighton University in Omaha.

**Public acceptance of diagnostic screening programs is on the increase.** In Tuscola, Ill., recently 820 persons (triple the number expected) turned out for free blood sugar tests. Abnormal levels were detected in 166 who were referred to their family physicians. Early reports indicate that 18 new diabetics and 5 borderline diabetics have been identified.



# State of the School Message

GLENN W. IRWIN, JR., M.D.

*I*T is a distinct pleasure to present the Dean's Annual State of the School Message on this 25th—our silver anniversary—of the I.U. School of Medicine's Alumni Day.

*For several years I have described our medical student body as remarkable. The number of Indiana residents who apply to our school has increased significantly in number and improved in quality. For example, the present freshman class consists of 273 students. The total number of applicants was about 1,700, of which 672 were Indiana residents. Of the 273 matriculants, which is the largest class in the nation, there were 8 non-residents, 39 women, and 11 black students. This class of 273 entered medical school on the multiple campuses of our Statewide System of Medical Education. 200 students entered at the Indianapolis campus, 30 at Indiana University-Bloomington, 12 at Purdue, 10 at Notre Dame, 10 at Ball State University and 8 at Indiana State University. The average academic performance of that entering class was 3.3 on a 4.0 scale.*

For the freshman class which will enter this fall, we again have a much larger group of Indiana residents applying over the previous year, and again the quality is tremendous. 784 Indiana residents are applying this year, which is an increase of 112 over last year. It is projected

that this entering class will number 290 students on the multiple campuses. Of the Indiana applicants for this class, 286 Indiana residents have an academic performance of 3.3 to 4.0, and 202 in-state students have a record of 3.0 through 3.2.

*For months the Admissions Committee has been meeting weekly to evaluate the many academic and non-academic achievements of these applicants. In spite of the fact that this school has achieved a marked increase in its number of entering students, it still finds itself unable to accept all students qualified for medical school. This is not just an Indiana problem; it is also a national problem. It will probably exist for a few more years, at which time a leveling off of the number of applicants is expected. Also, with the notable increase in new positions in the nation's medical schools during the '70s, this serious problem should be corrected.*

Medical school attrition, which in the '60s ran between 10% and 15%, now continues to be only about 1 to 2%. Our Senior Class of 214 students will receive their M.D. diplomas on Sunday, May 21st, at commencement ceremonies in the new Indiana Convention and Exposition Center. This class of 214 has an interesting record, in that 201 of the group took one or more of their elective senior courses off the Indianapolis Medical Center campus. Also, about half of their student time was taken off the campus, and in most instances in the community hospital system of Indiana. I am pleased to report that this year a

larger percentage of the senior elective time will be spent in the community hospitals outside the Indianapolis area.

*The full-time faculty of the school now numbers 370. In addition, there are 108 part-time members of the faculty and over 600 volunteer members. Although there has been a large increase in the number of full-time faculty members, the school still ranks in the fourth quartile of the nation's medical schools on the basis of student-to-faculty ratio. The education load of our faculty is tremendous, but I am very pleased to see that teaching has become the number one priority of our faculty.*

Since our last meeting, several new chairmen have been appointed. Dr. John Jesseph is professor and chairman of the Department of Surgery. He comes to Indiana from Ohio State, where he was Vice Chairman of Surgery. Also Dr. Eugene Klatte is now professor and chairman of Radiology, succeeding Dr. Jack Campbell. Dr. Klatte comes to us from Vanderbilt, where he was chairman of Radiology. Dr. Raleigh Lingeman is now professor and chairman of Otolaryngology, succeeding Dr. David Brown. Dr. Alan Fischer has become a full-time director of the Family Practice Program. Dr. Ward Moore has joined the Dean's Office as associate dean for basic medical sciences.

*I am pleased to announce today that Dr. John Nurnberger, professor and chairman of Psychiatry, has been awarded by Indiana University the academic rank of Distinguished Professor of Psychiatry. The School*

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Presented on the occasion of the 25th anniversary observance of the Indiana University School of Medicine Alumni Day, May 17, 1972.



of Medicine now has four such distinguished named professors. They include Dr. J. O. Ritchey, Distinguished Professor of Medicine; Dr. George Garceau, Distinguished Professor of Orthopedic Surgery; Dr. Harris B Shumacker, Distinguished Professor of Surgery; and now Dr. Nurnberger, Distinguished Professor of Psychiatry.

The faculty located in the community hospitals of Indiana are to be commended for their continuous upgrading of the educational programs for medical students and house officers in their respective hospitals. Education at the community hospital level has become a hallmark of the Indiana System of Statewide Medical Education.

*I am certain that many of you who have returned to the campus for the first time in many years are interested in our building program. Phase I of the University Hospital was completed in 1970, and has a bed capacity of 251. The second phase of the University Hospital is now about 50% completed, and should be open in approximately two years. This \$22 million expansion will contain space for Clinical and Anatomical Pathology, Obstetrics and Gynecology, special units for Medicine and Surgery, and a special unit for Psychiatry. We will request planning money of the 1973 Indiana General Assembly for architects' fees to help complete plans for the third phase. The complete hospital should have about 750 beds. Hopefully, it will be completed toward the end of the 1970s.*

In 1971, a major addition to the James Whitcomb Riley Hospital for Children was finished. This new addition will accommodate 131 beds. We hope that the new Riley Hospital Units A and B can also be planned and constructed during the 1970s. This would bring the total bed capacity of the childrens' hospital to 250.

*In about 60 days the Regenstrief Health Center, a new and major outpatient facility of the Marion County General Hospital, should be under construction. It will be located just south of the older section of General Hospital, and will face the university facilities. The five story building will provide the outpatient services of General Hospital, and probably the outpatient services of many of the university clinics. The eventual goal is to consolidate the out-patient and ambulatory care facilities of the university, of General, and perhaps, in the future, of the VA hospital into this one building.*

The number one capital request of the 1973 Indiana General Assembly for the Medical School is a major addition to the Medical Science Building, which was opened in 1958. This is urgently needed by the clinical and basic science departments to handle the heavy load of medical students, graduate students, and house officers.

*Other new buildings you may have noticed on the Medical Center campus include a major addition to the School of Dentistry, which was formally dedicated yesterday. Also immediately south of this tent is the new School of Nursing building which is nearing completion.*

The Statewide System of Medical Education continues to be a major School of Medicine program. The first phase of this system, which was launched by the 1967 Indiana General Assembly, has proved successful in the retention of our own graduates in the state, and in the attraction of young physicians from other states. In 1967, prior to the establishment of this program, there were only 428 interns and residents in all of Indiana's hospitals. Although the official count of house officers for July 1, 1972 is not complete, it appears that there will be approximately 240 more interns and residents in the hospitals of the state

than there were in 1967. This is an increase of 55%. However, the distribution of house officers throughout the state is still of concern to many of us. Some communities have gained very substantially in the number of house officers, whereas others have not fared so well. The "phasing out" of the freestanding rotating internship most likely has played an adverse role in the distribution of interns. Directors of Medical Education, Medical Education Center Directors and Medical School Faculty and Administration have concluded that a statewide system of combined or joint residencies must be established to help solve the maldistribution of house officers in Indiana. This will mean the establishment of primary care residencies in the key hospitals throughout Indiana with an understanding that a certain portion of this residency training in special areas can be provided at one or more Indianapolis hospitals.

*The second phase of Statewide Medical Education is progressing since it was launched in 1971. This phase is concerned with a substantial increase in the entering medical student class, utilizing the state universities of Indiana and the University of Notre Dame for the basic medical sciences. Although there has been a severe limitation of funding for this program, we now have entering medical students at Indianapolis, Bloomington, South Bend, Terre Haute, and Muncie, and this coming fall we will also have students in pilot programs in Gary and Evansville. If funding permits, the goal is an entering class of 320 students by the fall of 1973. This will mean increasing the entering class of Indiana by approximately 100 students over a four year period. Also this means that about 800 additional M.D.'s will be graduated by this school during the 1970's.*



Since these students from other campuses transfer to the Indianapolis Medical Center campus after they have completed most of their basic sciences, it is essential that our faculty and facilities be quickly upgraded on this campus. That is why it is crucial that we obtain the funding for the hospitals and the Medical Science Building at the Indianapolis campus.

*As we appraise our achievements to date and look to the future, we find numerous important questions facing the School of Medicine and our profession. For example, is medical education relevant to the needs*

*of all of the people for health care? Is the physician manpower shortage and distribution of physicians effectively being corrected? Is there really a commitment to the education of primary care physicians and where should this education be conducted? What should be the role of the Medical School and Medical Center in new and expanded models of health care service? What is the respective role of the Medical School and the communities of the state in regard to the distribution of physicians? What must the school and the profession do in regard to the containment of the cost of health*

*care, peer review, periodic licensure of physicians, residency training in community hospitals, continuing education, creation of new health careers, and improvement of the humanism or the art of medicine?*

To resolve these and other important questions will require the best thinking of the leadership of the profession, of the school, of the University, and of our citizens, who ultimately benefit from the delivery of our health care. I am confident that in Indiana we will be at the forefront in helping to solve these important problems for our state and nation.

**PLAN NOW TO ATTEND . . . .**

## A REAL ANTIQUES SHOW 17th INTERNATIONALLY FAMOUS CRUTCHER SHOW INDIANAPOLIS

**October 26, 27, 28, 29, 1972**

**Exposition Hall, State Fairgrounds, 1500 E. 38th St. (U.S. 36)**

**11 a.m. - 10:30 p.m.**

**Sunday 11 a.m. - 6 p.m.**

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130 top national dealers from 22 states in 20'x20' booths.

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# Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

## For more modern anemia therapy

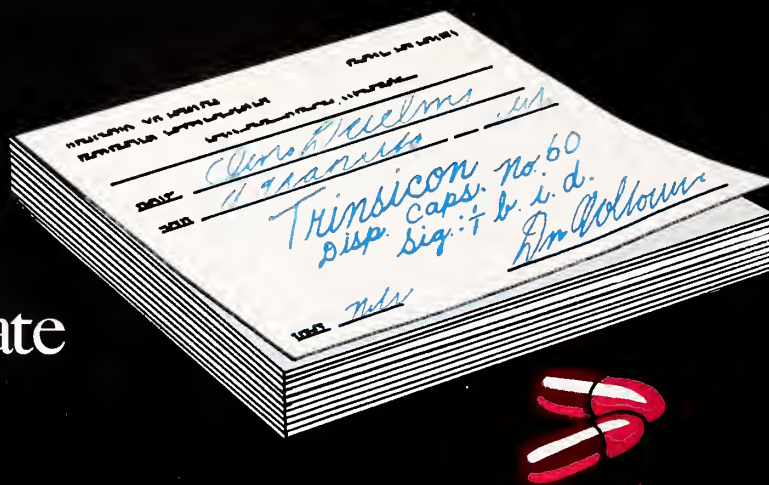
**Trinsicon<sup>®</sup>**  
Hematinic Concentrate  
with Intrinsic Factor

(See reverse side for prescribing information.)



# Trinsicon®

## Hematinic Concentrate with Intrinsic Factor



**Description:** Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly  
(containing Intrinsic Factor) . . . . . 240 mg.  
Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 7.5 mcg.  
(The total vitamin B<sub>12</sub> activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Iron, Elemental (as Ferrous Fumarate) . . . . . 110 mg.  
Ascorbic Acid (Vitamin C) . . . . . 75 mg.  
Folic Acid . . . . . 0.5 mg.

**Indications:** Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

**Vitamin B<sub>12</sub> with Intrinsic Factor**—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B<sub>12</sub> in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B<sub>12</sub> leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B<sub>12</sub>. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B<sub>12</sub> deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B<sub>12</sub> contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B<sub>12</sub>) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

**Folic Acid**—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B<sub>12</sub> deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B<sub>12</sub> interrelationship: (1) B<sub>12</sub> influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B<sub>12</sub> progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B<sub>12</sub>.

**Iron**—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

**Ascorbic Acid**—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

**Contraindications and Precautions:** Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin B<sub>12</sub> deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B<sub>12</sub> may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B<sub>12</sub>. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

**Adverse Reactions:** In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

**Dosage:** One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

**How Supplied:** Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500 and in Identi-Dose® (unit dose medication, Lilly) in boxes of 100.

(090971)

## Trinsicon®

### Hematinic Concentrate with Intrinsic Factor

### A Comprehensive Hematinic

Additional information available to the profession on request.

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Indianapolis, Indiana 46206



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# Anatomy of a Doctor.

You know what it takes to make a doctor. The motivation. The years of study and training. The dedication. The hard work.

But from the criticism leveled at doctors lately you'd think neither the public nor press had any idea.

It may surprise you, but the public does.

This was evidenced in a recent Harris Poll. In measuring public respect for U.S. leadership, it showed a drastic drop in the past five years. And "a majority of Americans is currently willing to express a 'great deal of confidence' in only one profession—medicine—on a list covering 16 types of activity." And that list included Congress and the Supreme Court.

People still look at their doctors as men to be respected and as men of integrity.

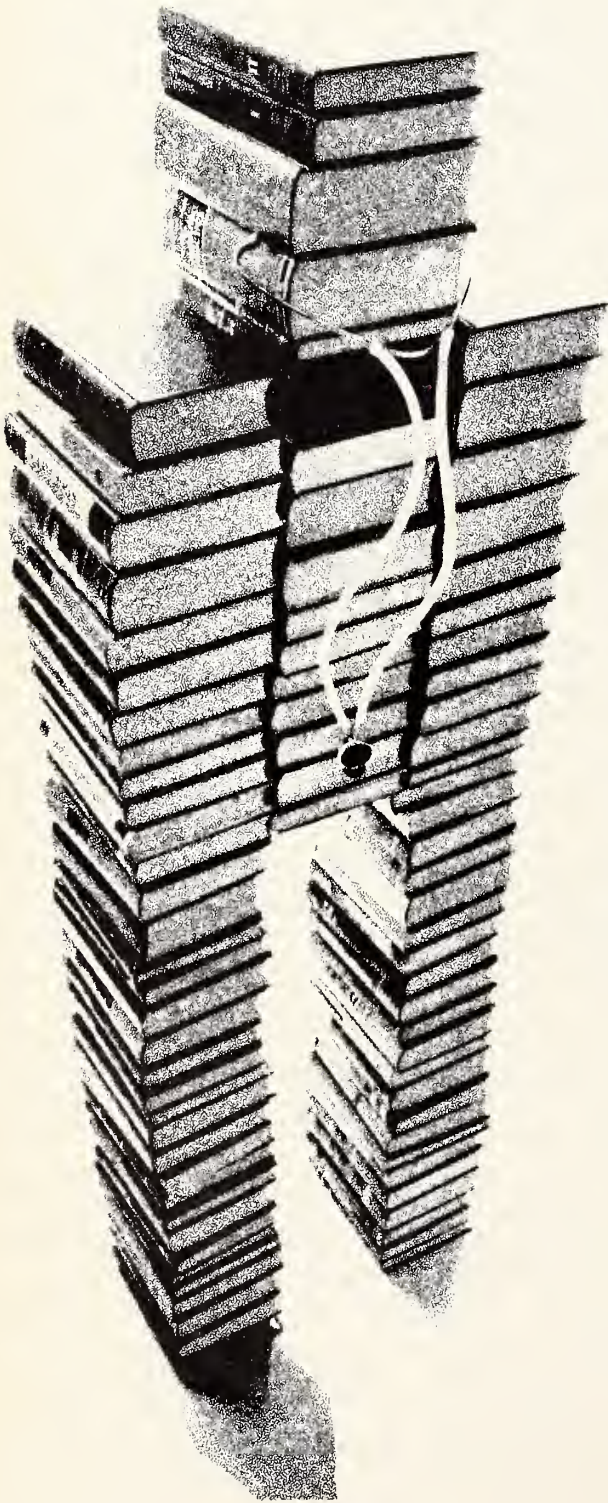
This is the true story of the American doctor. And one which the AMA is constantly telling the public as part of its communications program.

In newspapers and magazines, the AMA tells what it takes to be a doctor. American medicine's achievements. And to express the profession's concern by providing information to help every American lead a healthier life.

We can be an even more effective spokesman...with your support. Find out more about what the AMA does for you and the public. Send for a free pamphlet. Write: Dept. DW, at the address below.

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WE CAN DO MUCH MORE TOGETHER.**

American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610





# The Cooper Quiz\*

## "Self-Assessment"

JAMA, April 3, 1972

1. A trivalent Sabin polio vaccine is now produced in human cells. TRUE or FALSE
2. Of the "gas and vapor" poisonings, carbon dioxide is the principal offender. TRUE or FALSE

JAMA, April, 10, 1972

3. There is increasing resistance of gonorrhea to penicillin and tetracycline. Streptomycin is the next drug of choice. TRUE or FALSE
4. Spectinomycin hydrochloride I.M. in doses of 2.0 gm for males and either 2.0 or 4.0 gm for females appears curative against present day gonorrhea. TRUE or FALSE
5. Several antibiotics including tetracyclines are effective against gonorrhea in multiple doses over several days. But from the epidemiologic angle, effective single dose drugs are preferred. TRUE or FALSE
6. Penicillin G procaine combined with probenecid should be abandoned in the treatment of gonorrhea. TRUE or FALSE

7. The enzyme  $\gamma$ -glutamyl transpeptidase is perhaps the most reliable enzyme study in myocardial infarction. TRUE or FALSE

8. X-rays are best correlated to functional impairment in pneumoconiosis. TRUE or FALSE

9. A recent study indicates that furosemide can increase sodium excretion sufficiently to maintain sodium balance on an acceptable diet without increasing blood pressure in patients with chronic renal failure. TRUE or FALSE

10. Entero-Vioform is a drug commonly taken by tourists to prevent diarrhea when traveling in foreign countries. Recently it is suspected of producing a subacute myelo-optic neuropathy. TRUE or FALSE

JAMA, April 17, 1972

11. The antigen thought to be specific for adenocarcinoma of the colon is also present in fetal colonic mucosa. TRUE or FALSE
12. In a New York City study, detoxification of sick addicts in prison indicated that violence and suicides are more common with those being detoxified. TRUE or FALSE

13. In New York City, if all the jail space was used for the confinement of addicts

percent of the city's heroin users would still be in the community.

- |        |        |
|--------|--------|
| (a) 15 | (d) 49 |
| (b) 25 | (e) 76 |
| (c) 33 | (f) 90 |

14. Coronary disease associated with mitral valve impairment appears to be more common than with aortic stenosis. TRUE or FALSE

15. When remediable coronary artery disease is present in valve replacement candidates, both operations should be done at the same time. TRUE or FALSE

16. Tetracycline given to patients who are taking diuretics is associated with a significant elevation of the BUN. TRUE or FALSE

JAMA, April 24, 1972

17. Rheumatoid granulomas (by biopsy) are not rare in systemic lupus. TRUE or FALSE
18. Some authorities find a relationship between migraine and epilepsy. TRUE or FALSE
19. The most frequent complication of low tracheostomy is infection. TRUE or FALSE
20. The complication of posttracheostomy bleeding is more apt to occur with the tracheostomy below the fourth tracheal ring. TRUE or FALSE

Answers will be found beginning on page 1121.

\*We are indebted to Bill Snagg, M.D., Director of Medical Education, The Cooper Hospital, for permission to reproduce portions of "The Cooper Quiz." Published monthly by the Department of Medical Education, Cooper Hospital, Camden, N.J. 08103.



# The Woman's Auxiliary

## REPORTS TO ISMA



As you are well aware, this is a very important election year—not only for the future of medicine, but affecting the future of the country. We have many choices before us and it is to our advantage to be well informed. So this month I have asked our state legislative chairman, Mrs. G. Beach Gattman of Elkhart, to bring you up to date. Ruth has been serving in this capacity for the past three years and has made it a point to be on top of the situation and to keep the auxiliary abreast of all current legislation.

*Marjorie Smith*

**"The first requisite of a good citizen in this republic of ours is that he should be able and willing to pull his weight."**

This year each physician and his wife will have the opportunity to "pull his weight" as good citizens as we intelligently cast our votes in the national elections—and never has there been more at stake for medicine. The 1972 elections will select the Congressmen who will decide what form of National Health Insurance plan will be passed by Congress. Or, simply put, this election will decide how *you* practice medicine. Can you think of a better time to get involved in the political process?

Our legislative goals for this important year are:

1. To make sure each physician and his wife is a registered voter. (And everyone else in your family who is eligible to vote, too!) Be registered—then vote. It's the first requisite of a good citizen!

2. To make sure that auxiliary members and their husbands know their candidates for U. S. Congress, how they feel about the practice of medicine in general and the various national health insurance proposals before Congress in specific. Before you agree to support a candidate in any way, be sure he supports your views on medicine and is receptive to the opinions of others more expert than he. Accordingly, I have asked each county legislation chairman to contact the candidates for Congress from their district by letter, asking each for his views on medicine and national health. The responses to these letters are to be read at county auxiliary meetings in Sep-

tember and October, and/or printed in the county Newsletter wherever possible.

3. To foster support of the Indiana Medicine Political Action Committee (IMPAC), whose purpose is to elect state legislators and U. S. Congressmen of both parties who seek and respect the opinions of the medical profession on pending legislation. PAC membership provides the most effective means for physicians and their wives to participate in the political and governmental process which will ultimately determine how the practice of medical care will be structured during the coming decades. Total cost for one year is \$50.00 and may be sent to IMPAC, 3935 North Meridian Street, Indianapolis 46208. Can you afford not to join?

For physicians and their wives in Indiana the 1972 election is indeed a special election, for our own Dr. Otis Bowen is a candidate for Governor. No matter what party you may prefer, the knowledge that another M.D. has made it this far up the political ladder, with such outstanding qualifications, makes each of us a little prouder of the American political process. We're thrilled and proud and wish both Otis and Beth much success in the coming campaign.

It's up to each of us to help shape the destiny of medicine in the 70s. Let's do it wisely. As Omar N. Bradley wrote, "If you will help run our government in the American way, then there will never be danger of our Government running America in the wrong way."

*Ruth Gattman*





## ABSTRACTS, BOOK REVIEWS

### GENETIC DISORDERS OF THE ENDOCRINE GLANDS

David L. Rimoin and R. Neil Schimke, C. V. Mosby Co., St. Louis, 1971; 383 pages, \$32.50.

This slender volume is an altogether remarkable work of scholarship which deals with the genetic influence on endocrine function in a very systematic fashion.

The text is beautifully illustrated and extensively documented with several hundred references at the end of each of the nine chapters. While this book is not designed for casual reading, it should be a valuable reference source for all clinicians with patients exhibiting multiple endocrine disorders or having congenital and hereditary syndromes with associated endocrine abnormalities.

STEVEN C. BEERING, M.D.  
Indianapolis

### HANDBOOK OF PHYSIOLOGY — SECTION 4: ADAPTATION TO THE ENVIRONMENT.

Senior Editor, D. B. Dill. Williams & Wilkins Co., Baltimore, More than 1,000 pages, six pounds-plus by weight; innumerable charts and tables; no less than 65 chapters, each written by a renowned specialist in that specific sub-area. \$32.00.

This enormous volume more than fulfills its function as a "critical, comprehensive presentation of physiological knowledge and concepts" in the specific area of "Adaptation to the Environment." Prof. Dill states in his preface that so little is *really* known that precise, crisp discussion is difficult. He quotes one author-to-be who was approached for a chapter as saying "There seems to be too little known about this as yet to put in a handbook."

Spot-checking the various articles, one can really say amen to this acknowledgement. I am also reminded of a famous statement made by the late professor A. J. Carlson of the University of Chicago. "If you say 'I don't know' in three words, you flunk. If you say the same thing in three volumes, you become a Professor."

Having said all this, I can be much kinder and actually *recommend* this volume to the person desiring an overview of his particular area of interest. What is really known (to date) is presented quite simply and clearly. What needs further investigation is stated just as unequivocally.

The format is superb; the printing, binding and paper cannot be faulted. The references listed are fantastically detailed. Dr. Williamina Himwich gets kudos for her patience in the tedious task of preparing the subject index, checking the zillion references in most of the languages girdling the globe.

This is an interim task for which the American Physiological Society deserves the maximum of praise.

ARNOLD LIEBERMAN, M.D.  
New York

### UROLOGIC SURGERY IN INFANCY AND CHILDHOOD

Paul Mellin, with Paul Strohmer and Ludwig Stocker, English edition arranged by Heinrich Lamm, drawings by Rudolf Brammer, George Thieme Verlag, Stuttgart, 1970; 262 pp., 655 illustrations; \$41.55.

The original German title of this volume referred to it as an atlas but the name has been changed in the present American edition. It is really more than an atlas although it is certainly that also. However, the captions to the illustrations, taken as a whole, constitute a genuine textbook of pediatric surgical urology. The first 37 pages on pediatric anesthesiology, by Ludwig Stocker, can be considered a bonus, although a full measure of such knowledge would require a book in itself and more.

Each operation is preceded by a line drawing showing the recommended surgical position, and the "access" or type of incision is mentioned. So the reader's mind is made to think in practical terms of anatomy, position, surgical access and then of the procedure itself. I can't be over-enthusiastic in praise of this technique because of its clarity. The descriptive prose is stripped of excess verbiage and yet even worthy admonitions to the surgeon find space here.

The coverage of urological surgery in children is comprehensive and, generally, the authors' advocacy of various procedures seems to me to be mature and experienced—they probably have performed each of the operations recorded. There are a few notable absences in their coverage—specifically no mention is made of the Cecil urethroplasty for congenital hypospadias. This is not always the procedure of choice in America but it usually is a basis of comparison. They do like the Politano-Leadbetter operation for vesico-ureteral anastomosis and also favor the external trough technique for undilated ureters. In Germany they call this latter procedure "Gregoir," while we use the eponym "Lich." These are basic methods, and, as a whole, the authors seem to have an admirable facility for recognizing classical surgical approaches.

The translator, or as he is called, "arranger," Dr. Heinrich Lamm of Harlingen, Texas, has made a yeoman effort, although German syntax comes through occasionally. But, it must not be easy to translate scientific text without taking liberties with the meaning.

Let me make no serious reservations regarding this book; it is good. The clear manifestation of ideas and visual concepts is its outstanding quality. All surgeons operating on the infantile urogenital system will benefit from reading it, even if only to refresh the memory prior to operating. When the quality and abundance of the illustrations are considered, the asked price is reasonable. I personally will continue to take it down many times in the future.

RODNEY A. MANNION, M.D.  
La Porte

### DIABETES MELLITUS: DIAGNOSIS AND TREATMENT, VOL. III

Edited by Stefan S. Fajans, M.D., and Karl E. Sussman, M.D., American Diabetes Association, Inc., New York, 1971; 430 pages, \$5.75.

This book is the third in a series of publications undertaken by the American Diabetes Association Committee on Professional Education. The 81 authors have contributed their time and effort which accounts for the inexpensive price tag.



Volume III is not intended to replace the earlier volumes but rather represents a supplement to the information found in them.

The overall plan of the series is to make available in a highly condensed form the current thinking of a large group of authorities on the principal problems associated with Diabetes Mellitus. Frequently the opinions differ, as for example, in the accounting of the results of the use of oral hypoglycemic agents by the University Group Diabetes Program. There are five chapters which discuss the pathophysiology and various modes of treatment of diabetic retinopathy. There are two chapters dealing with a discussion of basement membrane disease and a superb chapter by Dr. Albert Winegrad and his colleagues on the polyol pathway in diabetic complications.

The book is of particular usefulness to the beginning student of diabetes in its precise, brief and authoritative handling of the subjects of management problems of the diabetic, pregnancy in the diabetic, emergencies in the diabetic, the long term problems of the diabetic and the ophthalmologic difficulties encountered in the diabetic patient. It is a superb effort, equally useful as a reference manual, as a textbook for the beginner and a splendid resource for teachers. At a single copy price of \$5.75 it must be the biggest bargain in medical textbooks today.

STEVEN C. BEERING, M.D.  
Indianapolis

## MEDICINE, ESSENTIALS OF CLINICAL PRACTICE

Chester Keefer and Robert W. Wilkins, editors, 62 authors, Little Brown & Co., Boston, 1970; 1,100-odd pages.

At \$10.00, this magnificent paperback volume is a must for all medicos from the lowliest student cramming for his finals to the erudite professor searching for an answer to an obscure point. On a recent trip to a medical meeting I took the text book with me for reading. I was fascinated by its concise, clear and crisp elucidation of so much that is usually obfuscated, even by excellent men. I was reminded by that famous comparison to a skirt: "Long enough to cover all points of importance and yet short enough to be of great interest."

The paper is excellent; the binding is good; so is the printing, and I could not find so much as a single typo error.

It is saddening to think that the senior editor, Professor Keefer, died just in February 1972. This monograph, in a very real sense, will become a long-to-be-remembered monument to his greatness as a teacher and molder of men.

ARNOLD LIEBERMAN, M.D.  
New York City

### Abstracts From Various Literature, Prepared by AMA

## CONTROLLED TRIAL OF TWO REGIMENS OF SUBCUTANEOUS HEPARIN IN PREVENTION OF POSTOPERATIVE DEEP- VEIN THROMBOSIS

I. C. GORDON-SMITH et al. (L. P. Le QUESNE, Middlesex Hosp., London) *Lancet* 1:1133-1135 (May 27) 1972.

A total of 150 patients undergoing major operations were divided into three groups: (1) controls, (2) those receiving three 12-hourly doses of 5,000 IU heparin and (3) those receiving 5,000 IU heparin every 12-hours for five days. The incidence of deep-vein thrombosis was 42% in the controls, 13.5% in group 2, and 8.3% in group 3.

## INFECTION HAZARD FROM STETHOSCOPES IN HOSPITAL

A. GERKEN et al. (Charing Cross Hosp., London) *Lancet* 1:1214-1215 (June 3) 1972.

Culture of stethoscopes used in a London teaching hospital showed that 21% carried coagulase-positive staphylococci, many of which showed multiple antibiotic resistance. Wiping stethoscopes with a disinfectant swab after use is recommended.

## BILATERAL NEPHRECTOMY FOR MALIGNANT HYPERTENSION

J. F. Mahony et al. (Karematu Memorial Institute, Sydney) *Lancet* 1:1036-1038 (May 13) 1972.

Nine patients with drug-resistant malignant hypertension and azotemia were treated by bilateral nephrectomy. Blood pressure was normal in all nine patients within two weeks of operation. Nine to 43 months after nephrectomy, four patients have functioning renal allografts, two are maintained on regular hemodialysis, and three have died (two after transplantation). Four patients no longer require antihypertensive therapy and the other two have easily controlled hypertension.

## RECOVERY FROM RABIES

M. A. W. HATTWICK et al (Center for Disease Control, Atlanta 30333) *Ann. Intern. Med.* 76:931-942 (June) 1972.

A 6-year-old boy developed clinical rabies 20 days after he was bitten on the left thumb by a bat, and two days after he completed a 14-day course of duck embryo rabies vaccine. The diagnosis of rabies was supported by epidemiologic, clinical, and laboratory investigations. Rabies virus was isolated from the bat but not from the child. Serum, cerebrospinal fluid, and brain tissue antibodies against rabies rose to levels compatible with clinical rabies rather than vaccination. Rabies serum neutralization titers peaked at 1:63,000 three months after onset. Recovery from the clinical illness was complete six months after onset, with no demonstrable residual.

## INTENSIVE CARE DELIRIUM: EFFECT OF OUTSIDE DEPRIVATION IN WINDOWLESS UNIT

L. M. WILSON (714 W Faulkner St. El Dorado, Ark. 71730) *Arch. Intern. Med.* 130:225-226 (Aug.) 1972.

The incidence of postoperative delirium in 50 consecutive surgical patients treated for at least 72 hours in an intensive care unit (ICU) without windows was compared to that in 50 similar patients in an ICU possessing windows. Over twice as many episodes of organic delirium were seen in the ICU without windows, and among those patients with abnormal hemoglobin or blood urea nitrogen levels the incidence of delirium was almost three times greater in the windowless unit. Age, type of surgical procedure, average temperature elevation following surgery, surgical staff, nursing care, or socioeconomic class of the patients had no effect on the incidence of delirium. The presence of windows is highly desirable in the ICU for the prevention of sensory deprivation.



## IN VITRO ESTROGEN SENSITIVITY OF BREAST CANCER TISSUE AS POSSIBLE SCREENING METHOD FOR HORMONAL TREATMENT

H. SALIH et al. (J. R. HOBBS, Westminster Hosp., London) *Lancet* 1:1198-1202 (June 3) 1972.

Fourteen malignant and five benign breast tumors were cultured in Trowell's T<sub>8</sub> medium containing different concentrations of 17 $\beta$ -estradiol. At least two distinct classes of breast tumors were found; one class required estrogens for survival, the other did not. Clinical follow-up of the malignant cases suggest correlation with the in vitro steroid dependence of the breast tumor.

## OUTBREAK OF HOSPITAL INFECTION CAUSED BY CONTAMINATED AUTOCLAVE FLUIDS

I. PHILLIPS et al. (St. Thomas's Hosp., London) *Lancet* 1:1258-1260 (June 10) 1972.

Between April 1971 and January 1972, 40 patients in St. Thomas's Hospital acquired infections, usually bacteremia or urinary or respiratory tract infections, caused by *Pseudomonas thomasi*, a previously undescribed organism related to *P cepacia*. The source of the outbreak was softened, deionized, and distilled water manufactured in the pharmacy and widely used throughout the hospital. When used for cooling bottles of parenteral and other sterilized fluids in a rapid-cooling autoclave, this water often remained on the bung beneath the crimped-foil seal, entering the bottle and contaminating its contents when the bung was disturbed. Water from the same source was also used in humidifiers of mechanical ventilators, resulting in general contamination of the machines and colonization of patients' respiratory tracts.

## PRESERVATION OF OVARIAN FUNCTION IN PATIENTS REQUIRING RADIOTHERAPY FOR PARA-AORTIC AND PELVIC HODGKIN'S DISEASE

J. W. BAKER et al. (D. W. SMITHERS, Royal Marsden Hosp., London) *Lancet* 1:1307 (June 17) 1972.

Transposition of the ovaries to midline position prior to para-aortic and pelvic irradiation was carried out in eight young women with Hodgkin's disease. Four of the patients resumed menstruation, one after two years of amenorrhea, and one patient became pregnant six years after irradiation for stage III Hodgkin's disease and gave birth to a normal child without symptoms of lymphoma.

## INCREASED FREQUENCY OF DIABETES MELLITUS IN PATIENTS WITH HUNTINGTON'S CHOREA

S. PODOLSKY et al. (VA Hosp., Boston 02130) *Lancet* 1:1356-1359 (June 24) 1972.

Six of ten patients with documented Huntington's chorea had an unusual form of diabetes mellitus characterized by marked hyperglycemia, resistance to ketosis, absence of glycosuria, and markedly elevated insulin levels in response to the administration of glucose or arginine.

## WARNING OF CARDIAC ARREST DUE TO VENTRICULAR FIBRILLATION AND TACHYCARDIA

M. A. BENNETT and B. L. PENTECOST (General Hosp., Birmingham, England) *Lancet* 1:1351-1352 (June 24) 1972.

The character and duration of electrocardiographic warning of cardiac arrest due to primary ventricular fibrillation and tachycardia were studied in 34 patients with myocardial infarction. Of 27 patients experiencing their first arrest after admission to the coronary care unit, 5 (19%) had no warning at all, 2 (7%) had warning for less than five minutes, and 20 had ventricular premature beats (VPB) for more than five minutes before arrest. The degree of ventricular ectopic activity before cardiac arrest may be less than is generally realized. Among seven patients readmitted, recurrent ventricular tachyarrhythmia and VPB were common before each episode.

### HELP FOR THE CONGENITALLY HANDICAPPED CHILD

It wasn't so long ago that congenitally handicapped children were allowed to reach school age or even later before being fitted with a prosthesis. In recent years, experience has shown that fitting at an earlier age produces more effective results—both mentally as well as physically. HANGER provides individually designed prostheses to give aid to the congenitally handicapped child. Children with "HANGER PROSTHESES" can live normal lives. Using their HANGER appliances they exercise freely, ride bicycles, roller skate, play basketball, tennis, and engage in most of the activities like other growing children. These activities enable the child to become self-reliant. Each HANGER prosthesis follows much the same design as those for the adult, but utilizes specially developed components of appropriate size, thus providing a smoother transition as the child grows into adulthood. HANGER also provides devices and techniques for the initial fitting of infants and problem cases. Training of children in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the attention span of young children is short, extreme patience is required. Some handicaps make an ideal gait-pattern difficult if not virtually impossible to achieve. It should be noted that complete cooperation of the parent is necessary regardless of the experience and ability of the therapist. (Often the parents pass on a sense of guilt that is completely unfounded as there are no known preventive methods to combat the problem of a congenital handicap.)

*Hanger*  
PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202  
312 E. McMillan St., Cincinnati, Ohio 45219  
416 N. Main Street, Evansville, Indiana 47711  
3004 S. Wayne Ave., Fort Wayne, Ind. 46807



# Continuing Education for Physicians

## Postgraduate Courses in Indiana—IUSM

### **Comprehensive Care of the Newborn**

**January 10, 1973**

This course has been prepared for physicians involved in the care of newborn infants. Current concepts in optimum neonatal care will be presented, including the diagnosis and management of common problems encountered in the neonatal period. Participants will discuss nutrition, oxygen therapy, infection, abnormal parent-infant interactions, genetic counseling, hematologic disorders, and other topics of equal interest. (IUSM)

### **Pediatric Neurology**

**January 25, 1972**

The postgraduate course entitled Pediatric Neurology will consist of a number of short presentations regarding common clinical problems in Pediatric Neurology. The orientation will be toward the non-neurologic practitioner. (IUSM)

### **Current Concepts in Endocrinology**

**January 31, 1973**

This is a course designed to provide general practitioners, internists and other physicians with current concepts in the diagnosis of hyper- and hypothyroidism, management of the adult-onset diabetic, the treatment of hyperlipidemia, the differential diagnosis and treatment of hypercalcemia, endocrine

management of metastatic breast carcinoma, therapy of severe obesity, the diagnosis of adrenal malfunction and other topics of clinical interest will be discussed by experts in the field. Adequate time will be allowed for general discussion by the audience. (IUSM)

### **Genetic Counseling**

**February 21, 1973**

Genetics is relevant to all medical specialties, especially with the progressive identification and control of environmental factors that contribute to disease. This year's course will have faculty of the Medical Genetics Department present didactic work followed by case studies and discussion of these presentations. (IUSM)

### **Cancer of the Gut: Cooperation in Diagnosis and Treatment**

**March 23, 1973**

Course content will focus on standard and newer diagnostic methods and refinements in the localization and characterization of neoplasia of the gut, including endoscopy, cytology and arteriography.

Emphasis will be placed on timing of the several approaches with the goal of early recognition. Treatment considerations will cover surgical and non-surgical methods as well as palliation of terminal states and the management of pain. (Atkinson Hotel)

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## **CHAMPUS NEWS**

Under CHAMPUS inpatient care normally will be provided in semi-private accommodations.

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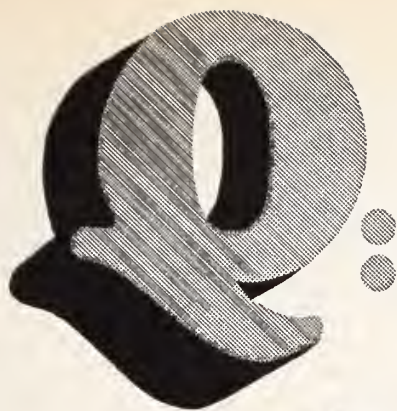
Under CHAMPUS successive inpatient admissions for similarly recurring procedures or for treatment of the same condition will be considered as one admission for the purpose of computing the CHAMPUS beneficiary's share of the charges, provided not more than 30 days elapse between the successive admissions.

\* \* \*

The services of a professional registered nurse, licensed practical nurse, licensed vocational nurse, or technical registered nurse outside an inpatient facility are payable as CHAMPUS outpatient benefits when the attending physician certifies that the services are medically necessary.

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# FUTURE MEETINGS, SEMINARS, COURSES

## Antibiotics and Infectious Disease Subjects of U of Iowa Conference

Antibiotics and infectious disease will be the subjects of a two-and-one-half day University of Iowa postgraduate conference October 26 to 28, in Iowa City. For information contact Office of Medical Education, University of Iowa, Iowa City 52240.

## St. Vincent Symposium Date Changed

The one-day symposium on Trophoblastic Disease and Early Uterine Carcinoma to be presented by Dr. Arthur T. Hertig and Dr. J. Taylor Wharton at St. Vincent Hospital, Indianapolis, has been rescheduled for November 1. The original announcement was for November 8. For details contact Dr. Paul F. Muller, Medical Director, St. Vincent Hospital, 120 W. Fall Creek Parkway, North Drive, Indianapolis 46208.

## Milwaukee to Be Site of Kidney Disease Program

Evaluation and care of the patient with kidney disease will be the theme of a two-day symposium on November 10 and 11 at the Marc Plaza, Milwaukee. It is offered by the Medical College of Wisconsin and sponsored by the Kidney Foundation and American Academy of Family Practice. The program is acceptable, hour for hour, for Academy credit. Registration fee is \$35, which includes coffee and luncheon on the 10th. Write The Medical College of Wisconsin, 561 N. 15th St., Milwaukee 53233.

## AMA Medical Aspects of Sports Conference to Feature "Indy 500"

At the luncheon session of the 14th National Conference on the Medical Aspects of Sports, William K. Keller, M.D., assisting physician at the Indianapolis 500, and Chairman of AMA's Committee on the Medical Aspects of Automotive Safety, will discuss "THE INDIANAPOLIS 500." At the evening session consultations and demonstrations on preventive and therapeutic taping, equipment fitting, devices to assess environmental heat stress and physical examinations will be staged.

The conference, which is sponsored by the American Medical Association under the auspices of its Committee on the

Medical Aspects of Sports, will be held in Cincinnati at the Sheraton-Gibson Hotel on November 26, 1972. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous 13 Conferences, the 14th will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to epileptics in contact sports, sports equipment, the young athlete, excessive weight loss among wrestlers, state medical societies, the family physician's role in sports medicine, drugs in sports and the Olympics in retrospect.

The Conference is open to athletic non-medical personnel, allied medical professionals and physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago 60610.

## Rheumatism Association Meeting Scheduled for December 8, 9

A one-and-a-half day scientific meeting of the American Rheumatism Association Section of The Arthritis Foundation will take place at the Pittsburgh Hilton Hotel on December 8 and 9, 1972.

For further information contact Miss Lynn Bonfiglio, Executive Secretary, American Rheumatism Association Section, The Arthritis Foundation, 1212 Avenue of the Americas, New York, N.Y. 10036.

## Sexual, Marital Inadequacy Seminar Set for Six Locations

The Institute for Comprehensive Medicine is sponsoring a three-day seminar on "Management of Sexual and Marital Inadequacy" to be held in Los Angeles, December 1 to 3. The program is acceptable for credit with the AMA Physician's Recognition Award. Tuition is \$175.00, including two luncheons. Similar courses will be held subsequently at Seattle Dec. 5 to 7, at San Francisco on Jan. 12 to 14, at Scottsdale Jan 16 to 18, at Denver Feb. 10 to 12, and at San Diego Feb. 14 to 16. Write the Institute at 9735 Wilshire Blvd., Beverly Hills, Calif. 90202.

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## About Our Cover

Reproduced on our cover this month is an oil on canvas (24" x 30") of Dr. Frank Barbour Wynn by the contemporary Hoosier artist, William G. Ashby of Zionsville.





## Becomes Cardiology Fellow

**Dr. Robert E. Edmands, Indianapolis**, was recently granted Fellowship in the American College of Cardiology. He was one of a group of 86 physicians of United States and Canada who were admitted this summer to the College's highest membership classification.

## New Hepatitis Test Licensed

The FDA has licensed a new procedure, developed by Abbott Laboratories, to test blood for the hepatitis antigen. According to FDA tests the new procedure will increase the detection of units of blood harboring the hepatitis virus. Previous procedures have detected only 20% to 25% of the bloods implicated in post transfusion hepatitis.

## HEW Grant to Extend Study of Child Developmental Problems

Indiana University School of Medicine has received a grant of \$191,000 from HEW for training and educational programs for specialists who will work with children with developmental problems. The grant will be used to strengthen and extend throughout Indiana the services and programs already established at Riley Hospital for Children.

## Dr. Caplin Elected

**Dr. Irvin Caplin, Indianapolis**, was recently elected vice-president of the East Central Region of the American Association for Clinical Immunology and Allergy.

## Offer Drug Cost Booklet

A booklet on drug costs, recently published by the Pharmaceutical Manufacturers Association, can be obtained by writing the Association at 1155 Fifteenth St., N.W., Washington, D.C. 20005. The title is "Rx Medicines and the Cost of Health Care." The documentation is based on the Firestone Index which reports that it now costs 12 cents less to buy the same number of tablets or capsules than it did in 1961.

## Children's Hearing Pamphlet Offered

"Helping the Child who Cannot Hear" is the title of Public Affairs Pamphlet #479. It outlines the process of making an early diagnosis which is important in order to effect a system of communication as soon as possible. The methods of education are explained. The pamphlet is for sale at 25 cents per copy, with discounts for quantities. Write Public Affairs Committee, 381 Park Avenue South, New York City 10016.

## Pediatricians Choose Officers

Officers chosen by members of the Indiana Chapter of the American College of Pediatrics at their summer meeting are: Chairman, **Dr. George F. Parker, Indianapolis**; vice chairman, **Dr. John R. Poncher, Valparaiso**; secretary, **Dr. Robert M. Sweeney, South Bend**; and treasurer, **Dr. William C. Ashman, Fort Wayne**.

## Physicians Urged to Support Medical Assistants Association

The Indiana Society of the American Association of Medical Assistants, Inc., encourages Indiana physicians to support their employees to attend the medical assistants' meetings in their area.

The organization's primary function is to create a professional assistant through education. This education is demonstrated in several forms: Academically through the AMA-AAMA accredited college programs, national and state publications, and continuing education at local meetings and state and national conventions.

In September Logansport Chapter hosted a symposium, "Medical Merry-go-Round." The areas covered were services of the Indiana State Board of Health, cancer, Medicare and Medicaid.

Phoenix, Arizona, will be the site of the national convention of AAMA October 17-21. A medical assistant attending this convention will return with renewed interest and valuable knowledge to function better in a physician's office. Encourage your assistant to attend!

A better-qualified employee results in a more efficient office with better care to patients.

The Indiana Society will have a booth at the Indiana State Medical Convention Exhibits; we will be looking forward to meeting you and serving you coffee.

For information on your nearest chapter or formation of a chapter, or for convention information contact Mrs. Robert D. Arnold, R.N., 5470 E. 16th Street, Indianapolis 46218; 317-353-2197.

## Cyclamate Damage Bill Passed

The House of Representatives has passed and sent to the Senate a bill to provide reimbursement from the government to domestic manufacturers, growers and distributors for the losses due to the FDA ban on cyclamates. Damages are to be awarded to claimants who prove injury by reliance in good faith on FDA's list of substances "generally recognized as safe."

## PMA Suggests Further Study

While everyone agrees that adequate steps must be taken to avoid mis-prescribing or overprescribing of drug products that are subject to abuse, rules that will have the effect of inconveniencing patients and increasing prescription costs should first be studied with the assistance of the medical profession.

That was the substance of PMA comments concerning one aspect of rules proposed by the Bureau of Narcotics and Dangerous Drugs. The rule would outlaw prescriptions calling for the lesser of a 34-day supply or 100 doses of any substance under Schedule II of the BNDD drug abuse controls. PMA said that since the cost of filling a number of prescriptions is greater than that incurred for one order,



and since patients may be required to visit their physicians more often than necessary, in order to obtain the needed prescriptions, the rule would needlessly raise costs for legitimately needed medications. The Association asked that the proposal be studied further before being made final.—**National Pharmaceutical News.**

### IUSM Receives Hartford Grant

The Hartford Foundation has awarded a one-year grant of \$65,777 to Indiana University School of Medicine for continuation of studies of communication along nerve cell fibers. The work was begun three years ago by Dr. Sidney Ochs. It studies the manufacture of proteins by nerve cell bodies and the rapid transport of the protein along the nerve fibers. Failure of this system is probably involved in muscular dystrophy, neuropathies, and other mysterious diseases of the nervous system.

### Dow Awarded Two HEW Contracts

The Indianapolis Division of the Dow Chemical Company has been awarded two investigational contracts with the National Institutes of Health. One for \$133,163 will provide a one and one-half year investigation on "Carcinogenesis Bioassay of Environmental Chemicals." The other for \$99,589 will study "The Effects of Anti-Cancer Agents on Reproduction and Teratology."

### Drug Registration Bill Passed

Next year, for the first time in history, the Food and Drug Administration may know the names, ingredients and manufacturers of every pharmaceutical preparation on the American market, and will have copies of the labeling and advertising material associated with them.

A bill (H.R. 9936) making that possible cleared the Senate Labor and Public Welfare Committee in June, following months of delay as a result of objections which Senator Gaylord Nelson raised over one provision. The sponsors of the bill decided that the provision was redundant anyway, and when they deleted it, Nelson raised no further objection.

Under the bill, which the House had passed earlier, FDA will get a semi-annual listing of all marketed drugs, prescription and over-the-counter. A major objective of the bill is to make it possible to eliminate every product containing a harmful ingredient with a minimum of confusion and delay. The PMA supported the measure in testimony in the House and Senate.—**National Pharmaceutical News.**



### Postgraduate Education Offered on Closed Circuit Live Television Series

During the 1972-73 academic year the Division of Postgraduate Medical Education and the Medical Education Resource Program of the I.U. School of Medicine are co-sponsoring a weekly live television series on the WAT-21 Closed Circuit Medical Education Television Network.

The hour-long programs will concentrate on demonstrations, procedures, patient and case presentations, panels, and open discussion with the listening audience. To facilitate discussion, two-way talk back capability will be available between the studio and the viewing centers.

Physicians and allied health professionals are invited to attend the hour long programs in person at the studio. Seating will be available. For those wishing to attend in person, the studio is located on the first floor, southwest wing of the University Hospital on the I.U. Medical Center Campus. There is no registration or admission charge for these programs.

All programs are approved by the Council on Medical Education of the AMA toward the Physicians Recognition Award, the American Academy of Family Physicians for prescribed hours' credit, and by the American College of General Practice in Osteopathic Medicine and Surgery for postgraduate credit.

Questions concerning any of the programs should be directed to the Division of Postgraduate Medical Education, Indiana University School of Medicine, 1100 West Michigan Street, Indianapolis 46202; telephone 317-264-8353.

Check with your network coordinator at your hospital for location of viewing areas.

(The activities of the Division of Postgraduate Medical Education are partially supported by a grant from the Indiana Regional Medical Program PHS-RM 43-04).

### Pharmacology Faculty Awards Announced for 1972 by PMA

The Pharmaceutical Manufacturers Association Foundation is offering faculty development awards for 1973 to help meet manpower needs in clinical pharmacology. Candidates in the junior faculty level at medical schools are preferred. The two-year awards are to begin July 1, 1973, and will cover salary features and other benefits. The deadline for applications is November 1, selections will be announced by December 15. Twenty-four such awards have been made in this program. Five individuals were recipients of awards in 1972.

GROUND was broken recently for the new \$10 million Regenstrief Health Center in the School of Medicine complex of the IUPUI campus. When completed, it will include outpatient facilities for both Indianapolis General Hospital and the Indiana University hospitals. It also will house the Regenstrief Institute for Health Care. Participating in the groundbreaking ceremony are, from left, Mr. and Mrs. Sam Regenstrief (the Connersville industrialist's gift of \$2 million helped make the project possible); Indianapolis Mayor Richard G. Lugar; Dr. Sprague H. Gardiner, chairman of the board of trustees of the Health and Hospital Corporation of Marion County; and Dr. Glenn W. Irwin, Jr., dean of the I. U. School of Medicine.



# Whats New?

Harmony Plastics is introducing the HANDI-NAP, a plastic device which dispenses one luncheon size paper napkin at a time with just the touch of a finger. It maintains the napkin supply in orderly fashion, preserves cleanliness, and, if used outdoors, prevents scattering of napkins by the breezes.

Mallinckrodt/Nuclear Radiopharmaceuticals announces a new one-step thyroid test in kit form. Called the Res-O-Mat ETR\* test, the kits are available in two sizes, 12 or 60 determinations. The test, in clinical trials, has a high degree of correlation with clinical diagnosis, and with the concentration of free thyroxine. Results are not affected by iodine, by pregnancy or by estrogen medication.

Biomedical Products offers a high capacity, free-flow disposable filter for removing microemboli from stored blood. The new Ultipor® Transfusion Filter is inserted into the blood bag port and readily accepts a standard blood administration set. The filter has a capacity of at least 10 units of 21-day-old blood.

Gould Instrument Systems has a portable battery-operated defibrillator. It is built with or without a cardio-scope. A separate charger is supplied with each unit. Useful both in hospitals and on the outside.

Schering announces Garamycin Pediatric Injectable. The antibiotic, packed in 10 mg vials, may be used intravenously or intramuscularly. It requires no mixing or refrigeration. It is well tolerated in neonates, infants and children. The risk of toxic reactions is relatively low in patients with normal renal function who do not receive the drug at higher doses or for a longer period of time than recommended.

Medcom announces a free 46-page catalog which describes more than 70 of its slide learning systems for medical instruction. Each of the slide booklet packages—called Medcom Famous Teachings in Modern Medicine—contains 100 or more 35 mm color transparencies and a hand viewer. To obtain the catalog write Medcom, 2 Hammarckjold Plaza, New York City, 10017.

Lockheed has introduced a patient monitoring system to alert the central nurse's station as to any cardiac irregularity exceeding a specified limit. The console also contains a five-trace oscilloscope and a cardiogram recorder. The system is suitable for intensive care wards or may be connected by telemetry for use on patients anywhere in the hospital.

Cambridge announces the new VS4 electrocardiograph, the first instrument to satisfy the specification standards elaborated by the American Heart Association in 1967. It produces clear definition of small, fine points in the tracing because of an improved stylus and curved platen writing method.



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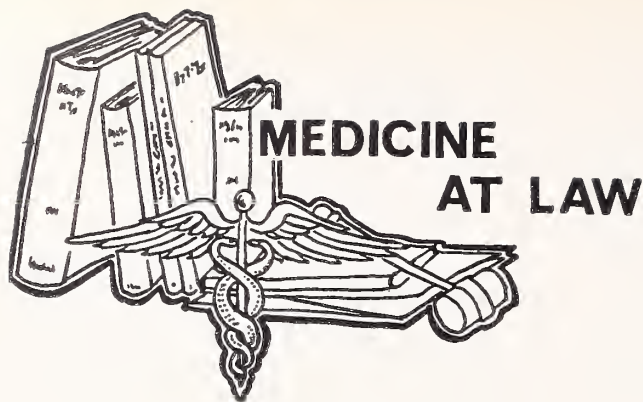
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**Damages Denied for Failure to Remove Intrauterine Device**—A patient who claimed that surgery for removal of an intrauterine device was necessary because of a physician's negligence was denied recovery of damages by a California jury.

The patient, a 29-year-old mother of four children, had an intrauterine contraceptive device inserted in 1966. When the physician examined her three years later, he could not reach the device by normal means. According to the patient, the physician did not advise her of a reasonable means for removal of the device.

The patient became pregnant and gave birth to a normal child. A year later she consulted a general practitioner, who called in a gynecologist for consultation. The gynecologist advised immediate removal of the device, and the patient was hospitalized. It was discovered that she was again pregnant, and upon her request an abortion was performed.

A month later, a surgeon removed the intrauterine device, which was in the peritoneal cavity. At the same time, he performed a tubal ligation.

In an action for malpractice, the patient contended that the first physician should have removed the device when he examined her. She claimed his negligence had been the cause of all her additional problems.

The physician testified that when

he first saw the patient he told her x-rays should be taken to locate the device, which could not be reached. He recommended surgical removal of the device, but the patient said she did not want to undergo such procedure. The physician further said that the patient ultimately received just what she wanted, which was a surgical procedure to prevent her from becoming pregnant.

The jury brought in a unanimous verdict for the physician. No motion was made for a new trial.—*Livingstone v. Varga* (Cal. Super. Ct., Los Angeles Co., Docket No. NEC 9801, Dec. 8, 1971).

**Damages Awarded for Injuries Due to Tight Cast**—An award of damages for injuries resulting from too tight a cast on a child's leg was upheld by a Texas appellate court. Release of the operator of an automobile that ran over a child did not release the physician who treated the child or require reduction of damages recoverable for his negligence, the court ruled.

The patient, a four-year-old boy, was struck by an automobile and suffered a compound comminuted fracture of the tibia and a fracture of the fibula in his lower right leg, just above the ankle. He was examined in the emergency room and later operated on by an orthopedic surgeon. The surgeon performed an open reduction to set the comminuted fractures and applied a circular cast, completely enclosing the lower

leg except for the toes.

Five days later, when gangrene appeared in the lower leg, the orthopedic surgeon called in a vascular surgeon, who transferred the boy to another hospital for additional treatment. A lumbar sympathectomy and a fasciotomy were performed, but the leg later had to be amputated just below the knee.

The boy's father filed suit against the driver of the automobile that struck the boy and also against the hospital and the orthopedic surgeon. Settlement was made with the driver and the hospital.

At the trial against the orthopedic surgeon, evidence was presented to show that the cast the surgeon applied had impaired the circulation in the boy's leg and was the cause of the gangrene. Another orthopedic surgeon testified that the impaired circulation was the result of edema or swelling caused by the injury, which did not have room to expand because of the cast. There was blockage of venous return and increased pressure, resulting in no arterial blood supply and death of the tissue.

About 24 hours after the operation, the surgeon split the cast and spread it slightly but did not return for about 48 hours, during which time the boy's toes were cold and blue. The nurse had informed him of the child's condition.

The surgeon spread the cast further at his second postoperative examination, and the toes regained warmth and color. However, six hours later they again lost warmth and color, but the surgeon did not return until 19 hours later. Although he completely removed the cast at that time, the color and warmth did not return, and he called in the vascular surgeon.

The surgeon contended that the loss of circulation was caused by vascular injury resulting from the initial accident when the automobile ran over the leg. There was



conflicting testimony by orthopedic surgeons as to whether the injury was caused by the accident or by the too tight cast.

The jury found that the physician had failed to use ordinary care to correct impairment of the boy's circulation and that such failure was a proximate cause of any additional damage to the boy's foot and leg over and above the damage caused by the accident. Damages were assessed at \$134,000, plus \$15,150 for future and necessary prosthetic devices. Payment of \$15,000 by the hospital was subtracted from this amount but not the \$8,500 settlement with the automobile driver.

On appeal, the orthopedic surgeon contended that the trial court had erred in failing to credit the \$8,500 received from the driver against the verdict. The appellate court said that release of a party or parties released only the named parties and no others. Therefore, release of the driver did not require reduction of the damages to be awarded against the surgeon.—*Leong v. Wright*, 478 S.W.2d 839 (Tex. Ct. of Civil App., March 29, 1972; rehearing denied, April 19, 1972).

**Psychiatric Exam Required of Complaining Witness in Sex Charge**  
—When the victim of a sex offense has a history of making accusations or where there is reason to doubt the story of the accuser, a psychiatric examination should be ordered, the highest court of Indiana held.

In such cases the trial judge should take advantage of the knowledge and expertise of experts qualified to pass on the competency of the accusers, some of whom have personality disturbances and who are inclined, for one reason or another, to make false accusations.

A 10-year-old girl accused a man of acts constituting sodomy and he was charged with that offense. Before the introduction of evidence, the accused filed a motion requesting that the child be given a psychiatric examination. It was brought to the attention of the trial judge that the child had accused other men of sexual misconduct, including her brothers and an uncle. The court denied the motion, and the case proceeded to trial.

On the stand, the girl admitted that she had told "stories" relative to sexual relations with men. On cross-examination she modified some of the accusations. She admitted that she told stories about persons with whom she was angry and that this was a way of "getting back at them."

The accused sex offender was found guilty of sodomy and an appeal was taken. It was urged on appeal that the trial court erred in overruling the motion requesting that the child be required to submit to a psychiatric examination before testifying.

The Indiana Supreme Court held that the matter of ordering a psychiatric examination is within the

sound discretion of the trial judge, but that in this case the refusal was not based on sound judicial discretion.

The court noted that modern psychiatrists have studied the behavior of errant young girls and women who have come before the courts. One form of psychic complex is that of contriving false charges of sexual offenses by men. The unchaste mentality, the court pointed out, "finds incidental but direct expression in the narration of imaginary sex incidents of which the narrator is the heroine or the victim." The real victims are too often the innocent men, for the respect and sympathy naturally felt by any tribunal for a wronged female helps to give easy credit to such a plausible tale. The court further observed that the most dangerous witnesses in prosecutions for moral offenses are the youthful ones, often mere children.

In reversing the conviction and ordering a new trial, the high court held that the report of an examining psychiatrist would provide an invaluable aid to the trial judge in determining the competency of the accuser. The court pointed out that it is imperative that the determination on the point of competency be made before the witness takes the stand.—*Easterday v. State of Indiana*, 256 N.E.2d 901 (Ind. Sup. Ct., April 14, 1970). ◀

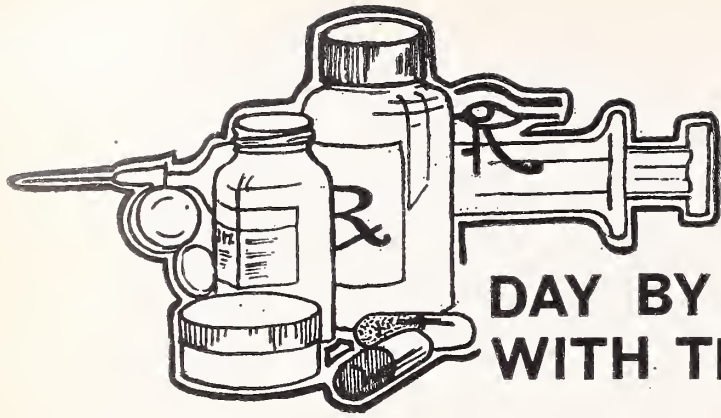
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## DAY BY DAY WITH THE F.D.A.

The Boston FDA found a re-packaging firm engaged in labeling frozen fish blocks as flounder. O.K., except for the fact that the fish was cod. The value difference was \$4,000. Such transactions are detected periodically in the New England fish industry which handles up to 750 million pounds of domestic and imported fish per year. Frozen filets are practically impossible to identify as to species except by the disc electrophoresis method which is infallible.

\* \* \*

One of the New Jersey State Fair exhibits which was most popular was a joint effort by the FDA and the American Can Company to educate the public on visual changes exhibited by cans of spoiled food. In four days up to 20,000 citizens witnessed the demonstration.

\* \* \*

A report from Ohio tells about the family who thought that some home-canned corn was not right, and fed it to the pigs. Ten pigs died. Other jars of corn disposed of the chickens, another pig and a hog. Botulism toxin type B was identified at the laboratory.

\* \* \*

Sodium sulfite retards decomposition of meat and masks the taste and odor of putrid meat. Also gives the meat red color and falsely makes it look fresh. In Kansas City 380 pounds of hamburger was destroyed when it was found, on analysis, to contain excessive amounts of sodi-

um sulfite. The meat cutter involved was arrested along with 30 pounds of "XXX Washing Powder" which he apparently had used as his source of sodium sulfite.

\* \* \*

The Mornin' Afta Company of Memphis was ordered by the court to destroy approximately \$34,000 worth of Mornin' Afta Hangover Remedy. The judge objected to the extravagant claims made for the Remedy, and also to the fact that the active ingredients were not listed.

\* \* \*

The Buffalo District found a large amount of a detergent, marketed as "Concern," totaling more than \$80,000 in value, which had been offered for sale to the public prior to any testing. FDA testing showed that it was toxic and irritating.

\* \* \*

Culture of baby powder manufactured in Illinois showed *Klebsiella pneumoniae* and *Clostridium tetani* organisms. The source seemed to be crude talc. The firm discontinued the product when it was found that natural talc could not be made to conform to their bacteriologic standards.

\* \* \*

There has been a recent 42% increase in detentions of imported products which do not meet FDA standards. The major items are mercury-contaminated tuna and swordfish, cheese with pesticide residues

and lead-leaching china and dinnerware.

\* \* \*

Manufacturers of plastic oven roasting bags will provide additional package instructions to insure their safe use. The Burns Care Institute of New York collected a number of cases in which bursting of the bag produced injuries. At a special meeting with manufacturers it was decided that full and complete instructions and the listing of precautions would eliminate the danger.

\* \* \*

Pocket-size and other miniature containers of oxygen are too small for any good use. FDA will issue regulations that emergency oxygen units, besides containing medical grade oxygen, should be able to maintain a constant flow of at least 6 liters per minute for a minimum of 15 minutes, have a content indicator, and a mask or other means for administration.

\* \* \*

An animal feed firm in Alabama recently destroyed 431,000 pounds of hominy feed and 250,000 pounds of white corn when it was found to be high in aflatoxin content. Aflatoxin is produced by growth of a mold, *Aspergillus flavus*.

\* \* \*

The Fuller Brush Company has suggested that reconditioning may render \$17,757 worth of hairbrushes fit for use. The bristles used in the brushes were imported from India. The FDA found the hairbrushes contained nits and nit fragments.

\* \* \*

The Pillsbury plant in Terre Haute is the first plant in the FDA Detroit District to adopt the FDA Self-Certification Program. It consists of quality control and certification reports on the honor system. The plant has instituted a comprehensive quality assurance monitoring system.



# The Cooper Quiz — Answers

JAMA, April 3, 1972

## 1. True

"For the first time, a vaccine grown in human rather than animal cell cultures, has been approved for use in the United States.

"A trivalent Sabin polio vaccine produced in the WI-38 strain of diploid human cells has been licensed by the Division of Biologics Standards. Pfizer Laboratories received the first license to produce the live, oral vaccine in human cells.

"All oral polio vaccines approved for civilian use in the United States up to now had been produced in monkey kidneys. Vaccines grown in human diploid cells have been used for some time in Europe and the US military (whose vaccine production is not licensed by DBS).

"Ten years of testing have indicated the human cells do not harbor any adventitious agents, according to Pfizer spokesmen. 'However, as with all other polio vaccines the possible low level risk of an association between poliomyelitis and the vaccine should still be kept in mind.'

"The trivalent vaccine contains the Sabin strains of poliovirus types 1, 2, and 3."

(April 3, 1972, p. 19, col. 2, para. 5)

## 2. True

"An estimated 3,000 Americans died from poisoning 'by solids and liquids' in 1970, the National Safety Council says, and another 1,600 succumbed to 'gas and vapor' poisoning.

"The council says the 'solids

and liquids' toll, which is an 11% increase over 1969, includes deaths from drugs, medicines, mushrooms, shellfish, and commonly recognized poisons. Cases of 'food poisoning' resulting from spoiled foods are classified as 'disease deaths' and are excluded from this count.

"Carbon monoxide is the principal cause, in the 'gases and vapors' category, where the toll was about the same as in 1969. Carbon monoxide is associated with cooking and heating equipment and standing motor vehicles, but excludes deaths associated with transport vehicles in motion."

(April 3, 1972, p. 24, col. 2, para. 10)

EDITOR'S NOTE: These two questions came from the section, "Medical News." This issue of JAMA is the "Annual Book Number"; interesting reading, but not clinical.

JAMA, April 10, 1972

## 3. False

"The emergence of increasing resistance of *Neisseria gonorrhoeae* to penicillin G and to the tetracyclines has led to a search for alternative antibiotics for the treatment of gonorrhea. Although many strains of *N gonorrhoeae* are completely resistant to streptomycin, high levels of resistance to a related aminocyclitol antibiotics, spectinomycin, have not been encountered among fresh isolates of gonococci. Spectinomycin was isolated in 1960, and spectinomycin sulfate appeared to be effective in the treatment of

gonorrhea in early clinical trials in England and in this country."

(April 10, 1972, p. 205, col. 1, para. 1)

## 4. True

"The more soluble dihydrochloride salt of spectinomycin (spectinomycin hydrochloride) has since become available, making possible the use of a larger dose of spectinomycin in a relatively small volume of diluent for single-dose parenteral treatment of gonorrhea. Recently, Cornelius and Domescik observed no failures among 108 men treated in Atlanta with 2.0 gm of spectinomycin hydrochloride intramuscularly, and only five failures among 100 women given either 2.0 or 4.0 gm of this antibiotic. Platts has reported equally good results with spectinomycin hydrochloride in a smaller number of patients in New Zealand."

(April 10, 1972, p. 205, col. 2, para. 1)

## 5. True

"Several antibiotics, including the tetracyclines, are highly effective in the treatment of gonorrhea when taken in multiple oral doses over a period of several days. Unfortunately, multiple-dose regimens require self-administration of medication at regular intervals by patients who are often unreliable, and who may surreptitiously distribute such medication in subcurative amounts to their sexual contacts. Effective single-dose regimens for gonorrhea, therefore, are preferable from both the clinical and the epidemiologic viewpoint."

(April 10, 1972, p. 208, col. 1, para. 2)



6. False

"A significantly greater proportion of men and a substantially greater proportion of women were cured with spectinomycin than were cured with the penicillin G regimens employed in this study. Although these doses of penicillin G procaine can no longer be recommended in many areas of this country, the use of penicillin G procaine for gonorrhea need not yet be abandoned. The single doses of penicillin G procaine which were relatively ineffective when used alone in the present study have previously been shown to be highly effective in 'penicillin-resistant' gonorrhea when 1 gm of probenecid was administered orally shortly before the injection. In the occasional patient with uncomplicated gonorrhea who does not respond to a probenecid-penicillin G procaine combination and in those patients who have a history of atopy or are allergic to penicillin, spectinomycin hydrochloride is the most useful alternative antibiotic for single-dose therapy at the present time."

(April 10, 1972, p. 208, col. 1, para. 3)

7. False

"The activity of  $\gamma$ -glutamyl transpeptidase ( $\gamma$ -GTP) was determined serially in 64 patients with suspected myocardial infarction. Of 38 patients with suspected myocardial infarction, only four showed early change of  $\gamma$ -GTP activity and six showed change between the fifth and seventh day. Of 26 patients shown not to have myocardial infarction, slightly over one-third had persistent false-positive elevation of  $\gamma$ -GTP. These studies failed to demonstrate a significant value to this enzyme determination."

(April 10, 1972, p. 217, "Abstract")

8. False

"From these findings it appears that conventional chest roentgenograms recognize some but not all of the constituent diseases in the composite disorder known as coal workers' pneumoconiosis. Unfortunately, roentgenographic recognition seems poorest for those disease processes which appear to be most closely correlated with functional impairment. There are obvious limitations in a retrospective analysis of dyspnea, but a number of previous studies of pneumoconiosis have found that predictions of functional impairment based on chest roentgenograms are often inaccurate. Such findings have implications for national policy because under the federal Coal Mine Health and Safety Act of 1969 which is now in operation, only miners with large roentgenographic opacities readily receive financial compensation. Those with small opacities are sometimes compensated on the basis of abnormalities revealed by physiologic tests, whereas those without opacities receive no compensation. This policy has been adopted because of uncertainty about the role of coal dust in the pathogenesis of the two most disabling components of the pneumoconiosis, namely emphysema and cor pulmonale."

(April 10, 1972, p. 226, col. 2, para. 2)

9. True

"Control of hypertension is important in the management of chronic renal failure. Data presented here support the view that hypertension in chronic renal failure develops because

many patients must have elevated blood pressure in order to excrete the amounts of sodium usually ingested. The data indicate that there is a wide spectrum with respect to the excretion of sodium by the diseased kidney and those patients who excrete the lowest amount of sodium have the greatest difficulty with control of blood pressure. Attempts to lower blood pressure by restricting sodium in the diet often cause such a marked reduction in sodium excretion that the patient has to reduce dietary sodium intake to an intolerably low level in order to stay in balance. In such patients preliminary experience indicates that furosemide can increase sodium excretion sufficiently to maintain sodium balance on an acceptable diet without an increase in blood pressure."

(April 10, 1972, p. 233, "Abstract")

10. True

"A peculiar, possibly new syndrome—subacute myelo-optic neuropathy (SMON)—has been reported to involve more than 10,000 persons in Japan. A few cases have also been seen in Germany, Switzerland, Great Britain, the Netherlands, and Austria. The clinical pattern is characterized by muscle pain and weakness, usually below the T-12 vertebra, optic atrophy in some instances, painful dysesthesias especially of the limbs, and often a significant alteration of the gait. Usually, a preceding diarrhea of one or two weeks' duration is treated with iodochlorhydroxyquin or clioquinol (Entero-Vioform).

"Since iodochlorhydroxyquin has been widely used for many years mainly in situations in which it is worthless, i.e., in



'Tourista,' without a neuropathy being recognized, the possibilities that special batches of the drug were different or that the Japanese were especially sensitive has been considered. The drug has been withdrawn from the market in Japan. It is by no means clear that the drug alone is responsible. Diarrhea of some duration seems to be an early and possibly necessary phase of the syndrome, although Gholz and Arons, as early as 1964, noted neurologic symptoms in a small percentage of those given iodochlorhydroxyquin as part of a prophylactic study. Recently, a syndrome resembling SMON in dogs and cats followed the feeding of toxic doses of clioquinol.

"A decade ago, one third of all US visitors to Mexico took iodochlorhydroxyquin in one form or another, and there is little reason to believe that the pattern has changed. Another and very similar halogenated quinoline — diiodohydroxyquin (Diodoquin) — is also widely used, especially in the United States. Etheridge and Stewart, in 1966, reported optic neuritis secondary to the use of diiodohydroxyquin."

(April 10, 1972, p. 243,  
col. 1, para. 1)

**JAMA, April 17, 1972**

#### 11. True

"There is currently much interest in the immunological diagnosis of cancer. An antigen specific for adenocarcinoma of the colon was described by Gold and Freedman in 1965. The antigen is present in tissue extracts from adenocarcinoma of the colon and in fetal colonic mucosa, but absent in extracts of normal adult colon. Subsequent studies by Gold and Freedman showed this carcino-

embryonic antigen (CEA) to be present in other malignant tumors of the gastrointestinal tract but not in any other tissue tested, normal or abnormal. Purification, partial chemical characterization, and localization of the antigen to the cell surface of the gastrointestinal epithelium have been reported.

"A radioimmunoassay capable of detecting plasma levels of CEA in the nanogram range was described by Thomson et al in 1969. With this procedure Gold and his group have been able to detect the presence of CEA in the plasma of about 96% of patients with primary adenocarcinoma of the colon. Gold considers carcinoembryonic antigen to be cancer-specific and specific for tumors originating within the gastrointestinal tract."

April 17, 1972, p. 361,  
col. 1, para. 1)

EDITOR'S NOTE: So that we do not mislead you from the real purpose of this paper, please allow us to quote another paragraph.

"The plasma assay of carcinoembryonic antigen (or tumor-associated antigen) detects tumors of the gastrointestinal tract with a high degree of reliability. Whether or not the test will eventually be able to consistently diagnose pre-clinical disease remains to be established. This possibility is currently the subject of much research in our institution and in other centers. An important new finding is the high incidence of abnormal results in children with neuroblastoma, and in patients with myeloma and macroglobulinemia. Independently of the obvious clinical usefulness of the test in following the course of the disease, the appearance of an epithelial antigen in nonepithe-

lial malignant cells is of importance in cancer immunology and in our understanding of the general theory of derepression of embryonal genes during the process of malignant transformation."

#### 12. False

"More than 22,000 heroin addicts have been successfully detoxified during the past nine months in the detention jails of New York City. By standardizing the dosage schedules and the dispensing routines, it has been possible to conduct this large program within the cell blocks of the institutions. Violence and suicides, which occurred frequently before the treatment was started, have been completely absent in the detoxification areas. The treatment program now is a starting point for placement of addicts in community-based narcotics treatment programs."

(April 17, 1972, p. 366,  
"Abstract")

#### 13. (f)

"A physician cannot treat addicts in prison without being struck by the futility of jailing them. Their crimes of theft and violence must of course be prosecuted, but jail does not eliminate the reason for the crimes, namely addiction. Addicts are not deterred or cured by confinement. In fact, the prison system, as it is now constituted, returns the addicts to the community in worse condition than when they entered, because social deterioration is added to their medical problem. Jails do not even serve the purpose of removing a significant fraction of the addicts from the streets. If all the space in all the jails in New York City were used for confinement of addicts, 90% of the city's heroin users would still remain in the community.



"However, the favorable response of inmates to the detoxification program suggests that Houses of Detention can make a positive contribution to the addiction problem, and prevent future crimes. Instead of serving merely as repositories for accused indigents who are awaiting trial, these institutions can use the otherwise wasted time of inmates in custody to provide needed medical treatment, and evaluate the medical and social problems that brought them there."

(April 17, 1972, pg. 369, col. 1, para. 2)

14. False

"Unsuspected coronary lesions are frequently overlooked in the clinical evaluation of valvular heart disease. Reports of postmortem findings showed severe coronary artery obstruction in at least one fourth of those patients who died from aortic stenosis. Coronary disease associated with mitral-valve impairment appears less common, probably due to the relatively younger age of the patients."

(April 17, 1972, pg. 372, col. 1, para. 1)

15. True

"When a remediable coronary lesion is recognized preoperatively, surgical treatment includes simultaneous myocardial revascularization along with valve reconstruction or replacement. Between Nov. 15, 1967, and July 15, 1971, 1,062 mitral- and aortic-valve operations were performed in 950 patients at this institution. Of this number, 80 (8.4%) also underwent myocardial revascularization procedures and, of the 80, 50 had aortocoronary bypass grafts."

(April 17, 1972, pg. 372, col. 2, para. 1)

EDITOR'S NOTE: The authors point out that the coronary artery disease must be evaluated by angiography preoperatively. It is not possible to assess accurately the severity of coronary constriction at operation.

16. True

"In conclusion, the data presented provide evidence that tetracycline therapy in patients receiving diuretics is associated with an increased risk of developing clinically significant uremia, particularly in those with an initially elevated BUN level. It therefore seems advisable to avoid tetracycline in such patients when alternative antibiotics can be administered."

(April 17, 1972, pg. 379, col. 2, para. 3)

JAMA, April 24, 1972

17. True

"Rheumatoid granulomas may occur in classic systemic lupus erythematosus (SLE) as either an early or late manifestation of the disease. . . . The occurrence of rheumatoid granulomas in both SLE and rheumatoid arthritis emphasizes the close association of the two disorders and that rheumatoid granulomas in adults are not unique to rheumatoid arthritis."

(April 24, 1972, pg. 515, "Abstract")

18. True

"Migraine and epilepsy have been considered clinically related for the best part of a century, beginning with the

statement by Liveing in his interesting book entitled *On Megrim, Sick-Headache and Some Allied Disorders* (Churchill, London, 1873). Basser has recorded the evidence for the relationship, and suggested that the fundamental basis was a process with the characteristics of the spreading depression of Leao. Except for the deliberateness of its regular march, spreading depression would appear to be related to spreading convulsion.

"The wonder is that more persons with migraine do not have epilepsy if both are predicated on a related cortical abnormality. The figures of Ely garnered over four decades ago are still quoted: 8.6% of his 104 patients with migraine had epilepsy, and 15.2% of his 171 epileptics had migraine. If these cortical phenomena are of a similar nature, the migraine sufferer would appear to possess the ability to retard and confine the cortical disturbance unlike most persons with epilepsy. A few patients can halt the spread of their epileptic seizure by one or another idiosyncratic maneuver."

(April 24, 1972, pgs. 521-522, col. 3, para. 3)

19. False

"Massive hemorrhage from erosion of the innominate artery is the most common delayed fatal complication of tracheostomy. The risks of high tracheostomy through the cricoid cartilage or first tracheal ring are well recognized. The complications of low tracheostomy below the third tracheal ring are less well appreciated. The most frequent fatal complication of low tracheostomy



# Annual Meeting Dates of Professional Medical and Allied Organizations

## AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION

**Date** June 24-28, 1973  
**Place** New York

## INDIANA STATE MEDICAL ASSOCIATION CONVENTION

**Date** October 14-18, 1972  
**Place** Indianapolis

## NORTHERN INDIANA PSYCHIATRIC SOCIETY

**Date** Fourth Wednesday of every  
month, September through June  
**Place** For location and program, inquire  
Jon Leipold, M.D.,  
919 E. Jefferson Blvd.  
South Bend 46622

## INDIANA SOCIETY OF INTERNAL MEDICINE

and

## AMERICAN COLLEGE OF PHYSICIANS, COMBINED MEETING

**Date** October 18, 1972  
**Place** Indianapolis Convention-  
Exposition Center

## INDIANA ACADEMY OF GENERAL PRACTICE

**Date** April 2-5, 1973  
**Place** Indianapolis Stouffer's Inn

## INDIANA PSYCHIATRIC SOCIETY

**Date** Second Wednesday of September,  
November, January, February,  
March and April  
**Place** For time and place, inquire Wes-  
ley A. Kissel, M.D., 1815 N.  
Capitol Ave., Indianapolis 46202

## INDIANA CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

**Date** May 3-5, 1973  
**Place** Indianapolis, Hilton

## INDIANA DENTAL ASSOCIATION

**Date** May 14-18, 1973  
**Place** Indianapolis Convention-  
Exposition Center

## The Cooper Quiz

Continued

is delayed hemorrhage from the  
innominate artery."

(April 24, 1972, pg. 577,  
col. 1, para. 1)

20. True

"Posttracheostomy hemor-  
rhage from the innominate ar-  
tery primarily occurs in trache-  
ostomies below the fourth

tracheal ring. Innominate artery  
hemorrhage has not occurred in  
more than 300 tracheostomies  
placed at the second-third  
tracheal ring performed by the  
cardiothoracic service of this  
hospital. Careful study of this  
complication indicates that low  
tracheostomy below the fourth

tracheal ring is the principal  
cause of innominate artery ero-  
sion."

(April 24, 1972, pg. 578,  
col. 1, para. 5)

EDITOR'S NOTE: This was  
the annual convention issue and  
clinical material was scant. ◀



# Deaths

## David A. Bickel, M.D.

Dr. David A. Bickel, 79, South Bend, who had been an Associate Editor of *The Journal* since 1953, died August 12 at St. Joseph's Hospital, South Bend.

Dr. Bickel was graduated from the Indiana University School of Medicine in 1921 and took his internship and residency at the University Hospital, Western Reserve University.

He was a diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology. He had served as president of the St. Joseph County Medical Society and as chief of staff of both St. Joseph and Memorial Hospitals.

He was a Senior Member of the Indiana State Medical Association. His connection with *The Journal* began in 1950 when he was chosen a member of the Editorial Board for a three-year term.

## Eugene L. Hedde, M.D.

Dr. Eugene L. Hedde, 70, a Logansport physician for 42 years, died September 3 at home.

A native of Logansport, Dr. Hedde was graduated from Jefferson Medical College in 1928 and interned at Brooklyn Hospital. From 1942 to 1946 he

served in the Army Medical Corps.

Active in many civic affairs, Dr. Hedde also served two terms as president of the Cass County Medical Society. Senior surgical consultant at the Logansport State Hospital for many years, he was on the consulting staff of White County Hospital, Monticello, and Pulaski County Hospital, Winamac. He also served two terms as chief of staff at both Memorial and St. Joseph Hospital in Logansport.

## J. William Hofmann, M.D.

Dr. J. William Hofmann, 85, Indianapolis surgeon for more than 50 years and former chief of staff at Marion County General Hospital, died August 8 in Methodist Hospital.

Dr. Hofmann had retired in 1963, after 52 years as a surgeon in Indianapolis. During part of this time he taught gynecology and surgery at the Indiana University Medical Center. He also headed the cancer clinic at General Hospital in addition to his staff work there.

Dr. Hofmann was a graduate of City College of New York and had interned at Bellevue Hospital.

He had served as a captain in the Medical Corps during World War I.

He was a member of the American College of Surgeons and was a Senior Member of the Marion County Medical Society and the Indiana State Medical Association.

## Harold Milton Trusler, M.D.

Dr. Harold M. Trusler, professor emeritus of the plastic surgery section of the Indiana University School of Medicine, died August 26 in an Indianapolis nursing home. He was 75.

He received his medical degree from the I. U. School of Medicine in 1924 and was a fellow in surgical research there for nine years. He was the first intern at Riley Hospital when it opened in 1924. In 1931 he was appointed assistant professor of surgery at I.U. and in 1934 chairman of the Cancer Clinic. He retired in 1964.

One of his leading contributions to medical science was a report on the treatment of major burns which was published in 1939. Dr. Trusler also had maintained an office for the private practice of plastic surgery since 1937. His chief interest was in the treatment of the cleft lip-cleft palate deformity in children.

A Fellow of the American College of Surgeons, he was a diplomate of the American Board of Surgery and the American Board of Plastic Surgery, and he held membership in numerous national and international professional groups. He was Senior Member of the Marion County Medical Society and ISMA.

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## Indiana Medical Foundation, Inc.

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

Contributions have been given in memory of the following persons:

Mrs. Ralph V. Everly, Robert S. Smith, Mahlon Miller, M.D., Judge Lloyd Claycomb, Mrs. Mary Black, Ross Griffith, Jr., Guy Spring, Gordon Batman, M.D., Miles Barton, D.D.S., Henry Bibler, M.D., Paul D. Crimm, M.D., G. O. Larson, M.D., Guy Morrison, Mary Rogers, Dale Lentz, Sr., D.D.S., Walter U. Kennedy, M.D., Russell Sage, M.D., Mr. Ralph Hamill, and E. Rogers Smith, M.D.



# Association News

## Executive Committee

Saturday, August 5, 1972

The Executive Committee convened in the Headquarters building on Saturday August 5, 1972, at 2:00 p.m. with Donald M. Kerr, M.D., chairman, presiding.

ROLL CALL showed the following present: Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Peter R. Petrich, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, Jr., M.D., Frank B. Ramsey, M.D., and James A. Waggener. Guests: Merritt O. Alcorn, M.D., and Richard Fairchild.

MINUTES OF THE MEETING held June 10, 1972, were approved on motion of Dr. Petrich seconded by Dr. Gosman.

THE MEMBERSHIP REPORT WAS accepted by consent.

### Headquarters Office:

**PURCHASE OF ADDING MACHINE**—The secretary asked permission to purchase an adding machine for the accounting department and this was approved by consent.

**PROPOSAL BY LEASING CO.**—A proposal by the McClain Leasing, Inc., of Anderson, Indiana, to also offer car leasing for members of the Association was approved on motion of Dr. Petrich seconded by Dr. Gosman.

### Treasurer's Report:

The Treasurer's report was approved on motion of Dr. Hoyt and a second by Dr. Petrich.

### Organization Matters:

**REQUEST OF COMMISSION ON MEDICAL EDUCATION**—The request of the Commission on Medical Education and Licensure for legal opinion concerning liability insurance for interns was read and the secretary was instructed to request such opinion, on motion of Dr. Gosman seconded by Dr. Petrich.

**LETTER FROM U.S. CIVIL SERVICE COMMISSION**—A letter from the U.S. Civil Service Commission concerning payment for examinations for disability retirement of civil and federal employees was reviewed and the secretary is instructed to inform the Commission that Indiana has no scheduled fees and to suggest to them that they might reform their examination form as under the present circumstances it

Number of members as of December 31, 1971 .....	4,557
Full dues paying members .....	3,999
Residents and interns .....	67
Senior .....	375
Board Remitted .....	54
Honorary .....	3
Military .....	31
Total 1972 members as of July 31, 1972 .....	4,529*
Total 1971 members as of July 31, 1971 .....	4,489
Number of AMA members as of July 31, 1971 .....	4,236
Number of AMA members as of July 31, 1972 .....	4,179
Full dues paying .....	3,713
Exempt, but active .....	466
	<hr/> 4,179
Number who paid state dues but not AMA dues as of July 31, 1972 .....	347
*Includes 3 honorary members.	

would be very difficult for physicians to make such examinations.

**LETTER FROM INDIANA HOSPITAL ASSOCIATION**—A letter from the Indiana Hospital Association concerning a joint meeting of the Executive Committees was reviewed and it was suggested that such a meeting be arranged, if at all possible, for August 30th.

**AAMA PROGRAM SPACE**—An invitation from the American Association of Medical Assistants, Inc., to purchase space in their forthcoming convention issue was reviewed. On motion of Dr. Dukes seconded by Dr. Petrich, the association will not purchase space.

**LETTER FROM INDIANA LIONS EYE BANK**—A letter from the Indiana Lions Eye Bank concerning the appointment of two liaison members between their organization and the Indiana State Medical Association was reviewed and, on motion of Dr. Gosman seconded by Dr. Petrich, Dr. Max D. Bartley and Dr. Robert W. Harger are to be named.

**LETTER FROM INDIANA ASS'N OF PUBLIC HEALTH PHYSICIANS**—A letter from the Indiana Association of Public Health Physicians, Inc., requesting the chairman of the Commission on Public Health be named to the Advisory Committee was approved on motion of Dr. Dukes seconded by Dr. McIntosh.

**LETTER FROM DR. INLOW**—A letter from Dr. Inlow concerning the request of the Rush County Medical Society for state association approval of their request for a Public Health Service Corps physician for that county was reviewed and, on motion of Dr. Petrich seconded by Dr. Dukes, this matter is to be referred to the Board of Trustees.

### Convention Matters:

**LETTER FROM RICHARD B. CALDWELL, M.D.**—A letter from Richard B. Caldwell, M.D., of the Wis-

consin Medical Center offering his services for a lecture on "Problem Oriented Records" during the annual meeting was reviewed and, on motion of Dr. Petrich seconded by Dr. Gosman, the secretary was instructed to thank Dr. Caldwell for his offer but there would be no time available during the annual meeting for this purpose.

**REQUEST OF THE AUXILIARY**—The request of the Auxiliary concerning whether shuttle bus service would be offered during the annual meeting from the hotels to the convention center was reviewed. On motion of Dr. McIntosh seconded by Dr. Hoyt, the secretary is to investigate this matter and report back at the next meeting of the committee.

**ENTERTAINMENT FOR BOARD DINNER**—The President discussed the possible entertainment program for the Board of Trustees annual dinner and, by consent, this was referred to the Board of Trustees.

**FINANCING ANNUAL MEETING**—Upon motion of Dr. Petrich and a second by Dr. Gosman, the Executive Committee is to request of the Board that the Board Finance Committee investigate methods of financing the annual meetings.

**BLUE SHIELD BREAKFAST**—The suggestion of Mutual Medical Insurance, Inc., (Blue Shield) to host a breakfast for the delegates in their new building was approved by consent with the suggestion made that this be held on Monday morning, October 16.

**EXHIBIT SPACE SOLD**—A report on the sale of exhibit space was given for the information of the committee.

### Blue Cross-Blue Shield Matters:

Several matters dealing with Blue Cross-Blue Shield were reviewed by the



committee and taken as a matter of information.

#### Legal Matter:

**LETTER FROM MR. HOLLOWELL**—Correspondence with Mr. Hollowell concerning the handling of a malpractice case and the efforts of another attorney to take over the case was reviewed. On motion of Dr. Petrich, seconded by Dr. Gosman, Mr. Hollowell is to be advised to retain these records.

#### The Journal:

**PRINTING OF THE JOURNAL**—The editor of The Journal reported on the change in the printing of The Journal and that they were ready for mailing on August 4th of the August issue as planned.

#### New Business:

**LETTER FROM ALABAMA MEDICAL ASSOCIATION**—A letter from the Medical Association of Alabama announcing that they proposed to nominate E. Bryce Robinson, Jr., M.D., for the office of vice president of the AMA, was read.

**LETTER FROM D. C. MEDICAL SOCIETY**—A letter from the District of Columbia Medical Society announcing they proposed to nominate Raymond T. Holden, M.D., for the office of president-elect of the A.M.A. was read.

**ANNOUNCEMENT FROM CALIFORNIA MEDICAL ASSOCIATION**—An announcement from the California Medical Association that they proposed to nominate Malcolm C. Todd, M.D.,

for the position of president-elect of the AMA was reviewed for the information of the committee.

#### Future Meetings:

An announcement of a meeting of the American Association of Foundations for Medical Care to be held at Sea Island, Georgia, August 27-31 was reviewed and no representative will be sent.

The AMA Communications Clinic will be held in Chicago August 28-29 and, by consent, it was agreed that the male staff of the association, the Executive Committee, and the chairman of the Commission on Public Information should attend this meeting.

32nd Annual Congress on Occupational Health will be held in Chicago September 10-12 and, on motion of Dr. Petrich seconded by Dr. McIntosh, the chairman of the Commission on Public Health was given permission to attend this meeting.

On motion of Dr. Dukes seconded by Dr. McIntosh, those individuals representing the association at various meetings, as a matter of policy from now on will be required to submit a written report to the association in order to have their expenses reimbursed.

The quarterly meeting of Indiana Health Careers, Inc., to be held in Indianapolis September 7 was reviewed and, by consent, Dr. Hoyt and Dr. Petrich will endeavor to attend this meeting.

The Governor's Eleventh Annual Conference on the Handicapped is to be held in Indianapolis October 3 and, by consent, Dr. Kirtley and Dr. Gosman

were authorized to attend this meeting.

**WASAMA Group**—On motion of Dr. McIntosh seconded by Dr. Gosman, the WASAMA group was given permission to use the Association building for a reception for wives of students on August 27, 1972.

**RECOMMENDATION OF DR. PETRICH**—Upon the recommendation of the President regarding a scientific exhibit by the Committee to Combat Huntington's Chorea Disease, a scientific exhibit space is to be offered to them for the forthcoming annual meeting.

**CONNERSVILLE MATTER** — Dr. Merritt Alcorn, president of the State Board of Medical Examination, and Mr. Richard Fairchild, the attorney for the Association, appeared before the committee for a discussion of the Connersville matter.

At this time the formal request from the Connersville doctors setting forth the areas which the ISMA should discuss with the Board were reviewed and these matters were answered by Dr. Alcorn and Mr. Fairchild. It seemed to be the consensus of those present that some provisions of the Foreign Physicians Law should be clarified with respect to what constitutes a preceptor. It was felt by the attorneys that this could be done by regulation.

On motion of Dr. Kerr and a second by Dr. McIntosh, this matter is to be referred to the Commission on Medical Education and Licensure.

**NEXT MEETING OF THE COMMITTEE**: There being no further business, the committee adjourned to meet again at 3:00 p.m. on Wednesday, September 27, 1972.

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## Review of Medical Topics-Clinical Approaches and Methods

The Indiana University School of Medicine is conducting several traineeships, clinical experiences, and short courses on the Medical Center Campus. These experiences are not structured or formally organized. They are set up for the individual physician to meet his needs. Each participant is matched with IUSM faculty members.

Experiences can be arranged for one afternoon a week for several weeks, for a month at a time, or for any duration necessary to accomplish what is requested.

If interested in this type of Continuing Medical Education, please contact either Mr. Steven Berkshire, program coordinator, or Dr. Steven Beering, associate dean, I.U. School of Medicine, 317-264-8353 and 264-8416 respectively.

A similar program is being formulated for physicians who have been out of practice and are now wishing to return.



# COMMERCIAL ANNOUNCEMENTS

FOR SALE: Officially, Attested, Advanced Register Angus bulls, also, frozen semen from proven sires. Write today for prices and production data.

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## ORTHOPAEDIC SURGEON WANTED

TO JOIN three man orthopaedic surgeons clinic in progressive, well industrialized, attractive, midwest city. Call collect or write for details to: Orthopaedic Clinic, 402 South Berkley Road, Kokomo, Indiana 46901. Telephone: (317) 457-4401.

NEW ULTRA-MODERN medical building has 3 suites available for immediate occupancy. Desirable especially for ophthalmologist, radiologist, E.N.T., O.B., Gyn., Pediatrician, family practice. Pharmacy next door. All utilities included except phone. Write J. A. Torrella, M.D., Torrella Medical Building, 5324 West 16th Street, Speedway City, Indiana 46224, or phone collect, 317-244-5942 or 317-244-4578.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220.

NOW AVAILABLE in new, modern Medical Building, 1400 sq. ft. of space suitable for orthopedic clinic. X-ray facilities also available. All utilities included except electricity and phone. Write J. A. Torrella, M.D., Torrella Medical Building, 5324 West 16th Street, Speedway City, Indiana 46224, or phone collect, 317-244-5942 or 317-244-4578.

WANTED — Physician interested in industrial medicine for rapidly growing industrial clinic in Indianapolis. Reply Box 372.

3 EMERGENCY ROOM PHYSICIANS wanted to staff new E. R. facilities of 200 Bed Hospital. 50 man multispecialty Clinic physically adjacent provides immediate consultation and support. No pediatric responsibility. Michigan Resort City on Lake Michigan. Salary negotiable. Many fringe benefits. Reply to: John Rasmussen, Administrator  
Burns Clinic Medical Center, P.C.  
Petoskey, Michigan 49770

ASSOCIATE IN FAMILY MEDICINE, TOLEDO. Young, dynamic family practice. Modern, well-equipped office. Must have baards or be working on same. For right physician "offer you can't refuse." I need help but am willing to wait for right persan. Reply Box 376, THE JOURNAL, ISMA, 3935 N. Meridian St., Indianapolis 46208.

COCOA BEACH, FLA. Nearest beach, Disneyworld. Charming cypress beach house, acean front, wide, safe beach, 3 bdms, 2 baths, family rm, and living rm., 2 TV's, completely carpeted and panelled. Air and heat. All appliances, linens furnished. Sleeps 10. Available Sept. and following months. \$250/wk. Ray D. Foster, M.D., 1944 N. Capitol Ave., Indianapolis, Ind. 46202.

## STUDENT HEALTH SERVICE\*

Excellent opportunity for generalist who desires regular hours and additional free time. Ideal working conditions, competitive salary and many fringe benefits.

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\*Join compatible group of physicians.

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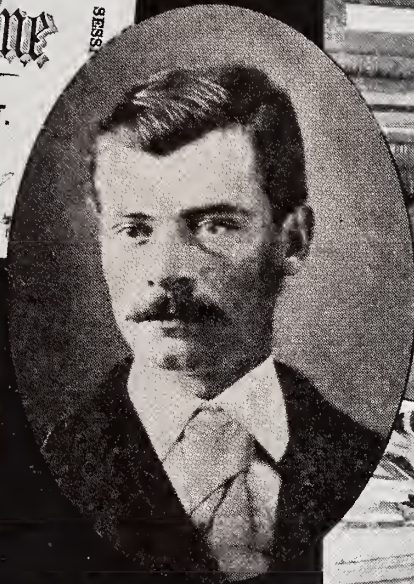
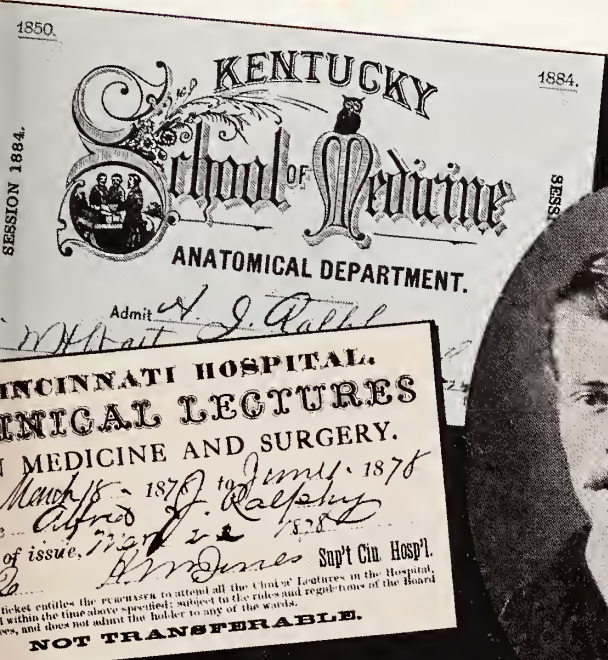


NOV 28 1972

# The JOURNAL

OF THE INDIANA STATE  
MEDICAL ASSOCIATION

November 1972  
Vol. 65 • No. 11  
Indianapolis,  
Indiana





The negative power of clinically significant anxiety  
in angina pectoris...

This man feels he is living  
on borrowed time.



During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,\* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)*

*Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.*

The positive power of  
adjunctive  
**Librium®**  
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10-mg, 25-mg capsules  
up to 100 mg daily  
for moderate  
to severe anxiety  
accompanying angina pectoris

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido — all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

\*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.



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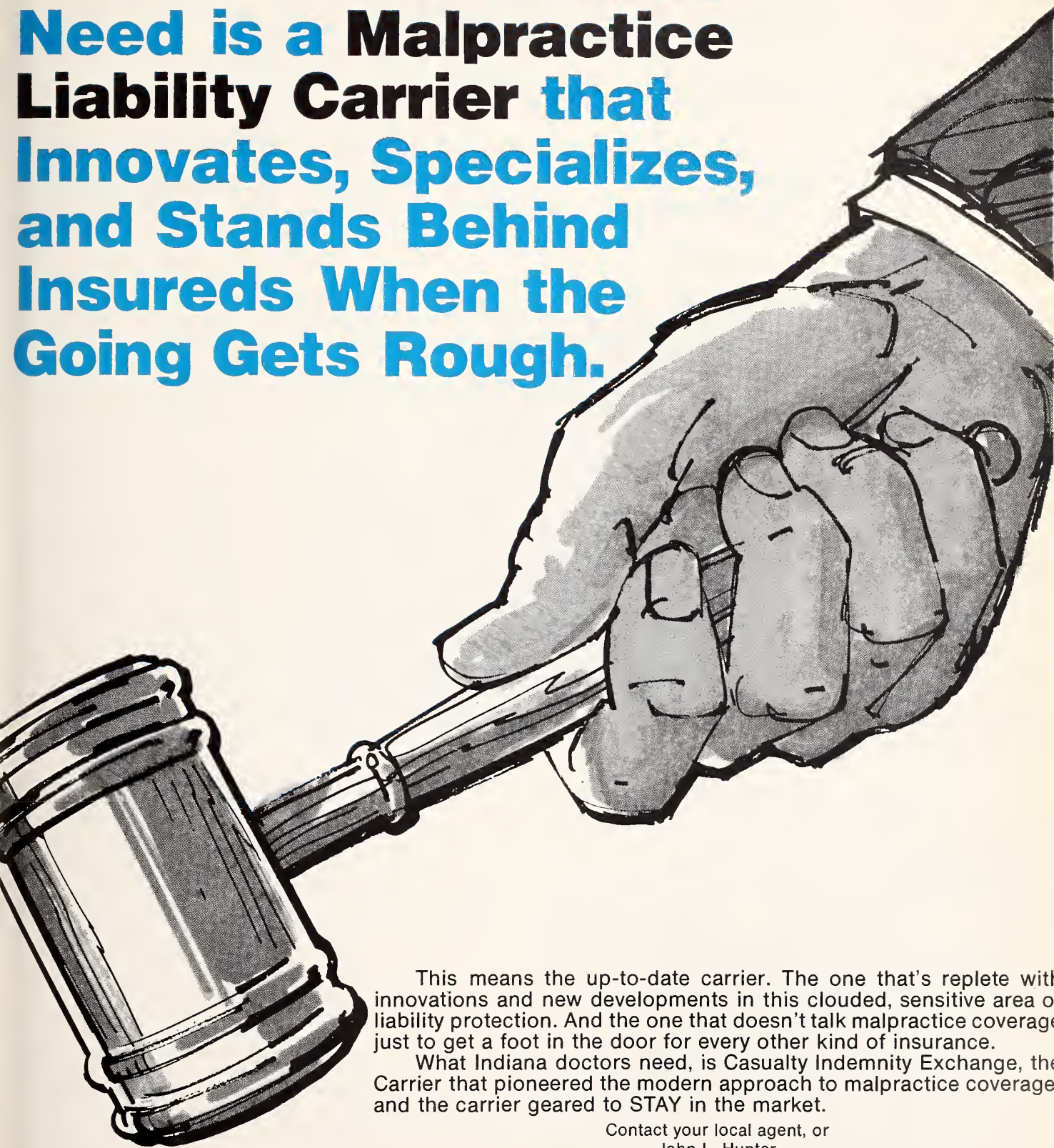


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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Romsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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Indexed in Hospital Literature Index.

About Our Cover

on page 1211



# Why send him to the islets of Langerhans?



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**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state.

**Do not give insulin without first checking blood and urine sugar.** 2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-D (6/72)

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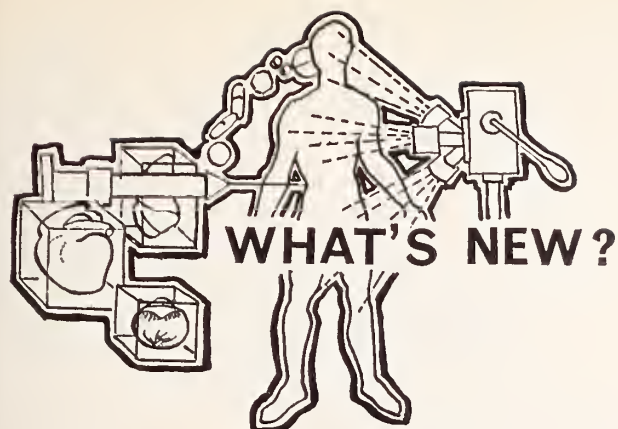
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\* \* \*

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\* \* \*

ITT Vulcan Electric announces a new Mini Circulating Liquid Heating Tank with temperature control and fail safe thermoswitch. The unit is designed for 100 lbs. pressure and may be modified to meet specific requirements. Suitable for medical and dental warm-water tanks and many laboratory applications.

\* \* \*

Lakeside Manufacturing announces a new, 32-page, full color catalog illustrating the newest line of stainless steel carts and accessories suitable for hospitals and laboratories. Address is 1977 S. Allis St., Milwaukee 53207, Attn: Dept. 133.

\* \* \*

"Community at the Crossroads" is the name of a drug education simulation game designed for use by teachers and students and community workers. It is a two-hour to five-hour game simulation of a community response to the problem of drug abuse. The kit consists of 34 manuals and 128 cards and is priced at \$13.75. Order from Public Documents Distribution Center, Pueblo Industrial Park, Pueblo, Colo. 81001.

\* \* \*

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9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—James A. Harshman, Kakama	Oct. 1975
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

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2.		J. S. Brown, Carlisle	Bloomington
3.	Claude J. Meyer, Jeffersonville	Robert K. McKechnie, Jeffersanville	September 1973, Clarksville
4.	Kenneth Schneider, Columbus	C. David Ryan, Columbus	May 9, 1973, Columbus
5.	James C. Lett, Greencastle	J. Franklin Swaim, Rockville	May 23, 1973, Greencastle
6.	John Moenning, Greenfield	Davis W. Ellis, Jr., Rushville	May 2, 1973, Rushville
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	June 6, 1973, Muncie
9.	Lawell R. Stephens, Covington	Theodore C. Person, Veedersburg	June 14, 1973, Attica
10.	Lambro Dimitroff, Hammond	Mario D. Mansueto, Munster	May 30, 1973, Hebron
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	Sept. 19, 1973, Logansport
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	
13.	James Rimel, Plymouth	David L. Spalding, Mishawaka	





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

The American Medical Association supported a two-year extension of the federal National Health Service Corps program under which Public Health Service personnel are assigned to areas with critical health manpower shortages.

Richard E. Palmer, M.D., a member of the AMA Board of Trustees, told the House Health Subcommittee, that the Association believed that the NHSC program, which got underway 18 months ago, was having "an auspicious beginning" and promised "to help alleviate the maldistribution of health personnel affecting shortage areas." He said, "its capabilities for bringing needed services into shortage areas are yet to be fully demonstrated."

"Additional experience will permit a fuller evaluation of the program's potential," Dr. Palmer said. "In supporting the NHSC, however, we believe it is essential that incentives now contained in the program are retained so that we may hopefully achieve our overall objective of meeting community needs on a long-term, continuing basis."

The AMA spokesman objected strenuously to a proposed deletion of a requirement for certification by state and district health societies that such health personnel are needed before assignment to a particular area.

"... Much of the ... planning to date has been centered around community participation in the NHSC program to further encourage the Corps physicians, dentists and other professionals to feel they are part of the community life," Dr. Palmer said. "We urge this committee not to take any action now which would block communities and professionals from attaining this goal."

"Certification by the physicians' or dentists' peers—the local members of his own profession—that his services are needed, together with concurrence by local government, provides the strong and necessary base of community acceptance and participation in his assignment. Removing this base could erect barriers and

prevent the level of contact and rapport with peers which are significant factors in stimulating the professional man to establish professional roots in a community.

"Furthermore, the record of cooperation by the medical profession at the local, state, and national levels speaks against the proposed amendment deleting the certification provision. The AMA has worked closely with the NHSC to help make the NHSC a reality.

"... At the Corps' request, the AMA has also distributed to all state medical associations and county medical societies brochures on the program, together with lists of NHSC personnel in central and regional offices to be contacted, requesting assistance in identifying areas particularly short of health manpower. All of these activities, and others, have been undertaken to inform state and local medical societies of the program's interest, method of operation, and goals.

"Most recently the Association has contracted with the Corps for the AMA to recruit physicians to serve in areas of need on a short-term basis. This undertaking, which we call 'Project U.S.A.,' will be a valuable adjunct to the Corps in the operational phases of its program.

"In short, ... the AMA has actively provided assistance in the implementation of the NHSC. The medical profession shares ... with government, and with communities the common goal of getting needed medical services into shortage areas.

"Even more directly than our activities at the national level, we believe that the measure of success to date of this new program can be attributed to the cooperation received at the local level from the various medical communities. It should be kept in mind that the great number of assignments of physician personnel made in this program to date have been possible *because* the local and state societies have certified to the need for such health personnel. As a fact, in some

Continued



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## **MONTH IN WASHINGTON**

Continued

instances, the medical society has been a moving party in seeking assignment of personnel under this program.

"... we believe that the foregoing is strong evidence that the active participation of organized medicine is to the advantage, and not to the detriment of the program. We must assert strongly that we are opposed to the deletion of the present certification requirements in the law. The record of cooperation warrants continuing these requirements. The absence of such requirements could defeat the goal we all share."

The AMA also recommended:

Continuation of a provision giving the Secretary of Health, Education, and Welfare latitude as to the use of PHS facilities, rather than requiring their use as proposed.

Against providing additional medical training scholarship arrangements in connection with the program.

### **Heart, Lung Disease Research to Get \$1.38 Billion**

President Nixon signed into law legislation providing for expanded research programs to combat heart and lung diseases.

The National Heart and Lung Institute is authorized to increase its expenditures for such research to \$1.38 billion over the next three years.

The new law provides for a comprehensive program for research into the cause and the prevention of all forms of heart, lung, and blood diseases; research into basic biological processes; research into techniques, drugs and devices used in diagnosis and treatment; establishment of programs for field studies and large-scale testing and . . . demonstration of preventive therapeutic and rehabilitative approaches, including emergency medical services for persons suffering from heart and lung diseases; public and professional education relating to all aspects of these diseases.

The bill also authorizes the Heart and Lung Institute to provide for the development of 15 new centers for basic and clinical research into the diseases of the heart, blood vessels, and blood, and 15 new centers for basic and clinical research into lung diseases.

The research program for these diseases is upgraded similarly to the expansion of cancer research authorized last year.

### **Federal Military Medical School, Scholarships to Civilian Medical Schools Authorized**

Establishment of a military medical school is authorized under a recently enacted law.

A companion program will provide up to 5,000 full federal scholarships in effect at one time for would-be physicians to go to civilian medical schools if they

agree to serve in the armed services for five to seven years after graduation. The scholarships would provide the full cost of tuition and fees and \$100 a week living allotment.

The military medical school is to be called the Uniformed Services University of the Health Sciences and is to be located within 25 miles of Washington, D.C. It will be set up to have 100 graduates a year.

Authorization of the military medical school capped with success a long fight of Rep. F. Edward Hebert (D., La.), chairman of the House Armed Services Committee. This year, the House approved the school but the Senate only approved a study of the proposal. However, Hebert succeeded in getting the House-Senate conferees to approve establishment of the school.

A report to the conference on the legislation said the Senate conferees "pointed out their concern over the apparent lack of any clear consensus in the government and the health professions as to the need and desirability of establishing such a university . . . and questioned the overall philosophy embodied in the principle of establishing a university of this type entirely supported by federal funds."

Related legislation, which was supported by the American Medical Association, would raise the pay of military physicians to attract them to the armed services. Ernest B. Howard, M.D., executive vice president of the AMA, wrote the House Armed Services Committee:

"The American Medical Association supports the principle of providing special incentives through which the Armed Forces may secure and retain qualified medical officers on active duty. This approach is entirely consistent with the concept of an all-volunteer Armed Force, which would require adequate manpower in the critical health professions. We support incentives designed to provide adequate medical manpower on a more equitable financial basis."

### **Betterment in Patient Survival in Some Forms of Cancer Reported by NCI**

A report of the National Cancer Institute indicates a substantial betterment in patient survival in some forms of the disease.

The fourth annual "End Results in Cancer" was prepared by the institute-sponsored End Results Group. It summarizes the survival experience of white patients diagnosed with cancer from 1940 through 1969 in more than 100 United States hospitals. Similar information on black Americans is currently being collected and analyzed for future publication. The data cover 52 anatomical sites of cancer, treated by surgery, radiation and chemotherapy. Varying survival rates up to 15 years are given for each form of cancer.



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Continued

The report indicates several cancer sites for which there is marked improvement in patient survival. The three-year survival rates for patients whose cancers were diagnosed from 1965-69 show an increase over the rates of those diagnosed from 1940-49 for the following:

Types of Cancer	3-Year Survival 1940-49	3-Year Survival 1965-69
Bladder	48%	62%
Brain	28	37
Chronic lymphocytic leukemia	33	53
Larynx	47	67
Melanoma of the skin	49	74
Multiple myeloma	10	27
Prostate	49	66
Thyroid	67	86

Other findings in the report:

Other cancers for which there have been important increases in patient survival since the 1940s are childhood leukemia, Hodgkin's disease and breast cancer. The one-year survival rate for children under 15 with leukemia indicates continuing progress and provides hope for further improvement. The rate has increased from 36% in 1955-64 to 59% in 1965-69. Among children with acute lymphocytic leukemia diagnosed in 1965-69, the one year survival rate was 67%. Due to greatly improved methods of chemotherapy, radiation techniques and life support systems, the three year survival rate for children has increased from less than 6% to 15% over the past 10 years. This represents the results achieved in a broad cross-section of hospitals.

Similar progress has also been noted in the treatment of patients with Hodgkin's disease. Twenty years ago only 35% of Hodgkin's disease patients survived three years; among patients diagnosed in 1965-69, 61% survived three years.

The outlook has also improved for women with breast cancer. For all stages of breast cancer, the three-year survival rate has increased from 63% 20 years ago to 72% in the most recent time period. Of patients with localized disease diagnosed during 1965-69, 91% were alive three years after diagnosis.

However, there has been little or no improvement in life expectancy for patients with lung cancer and cancer of the pancreas. Lung cancer is the most common male cancer, with 62,000 new cases and 56,000 deaths annually among U.S. men, and incidence is still increas-

ing. There has been little change since the 1940s in the proportion of cases classified as localized at diagnosis —only 18% in 1965-69. However, treatment results for localized forms of the disease have improved. For all lung cancers, the three-year survival rate is only 11%; for localized disease, the three-year rate has increased from 17% in the 1940s to 39% in 1965-69.

Survival rates for cancer of the pancreas have shown no improvement over the past 20 years. During this time interval incidence has risen from 7 cases per 100,000 persons to 9 per 100,000. An estimated 19,000 new cases are diagnosed each year in the United States. Over 90% of these patients die within one year. The three-year survival rate of the 1940s, 2%, for all stages of this disease has not improved in recent times. Even when detected in the early stages, the three-year survival rate is still only 4%.

Most cancers are diagnosed after middle age. Seventy-five per cent of all cancers among U.S. men and 63% of cancers in women are diagnosed at age 55 or over. Generally, the outlook for survival decreases with age. For cancer patients 15 and under, however, life expectancy is as low as for patients 65 years of age or older.

Women survive longer after cancer diagnosis than men. For example, only 31% of men with cancer survive five years or longer while 42% of women patients live 10 years or more. This pattern holds true for localized as well as for all stages of cancer, and for each age group.

The marked survival advantage of female patients is due in part to the fact that, for the major cancers in women (breast, colon, uterine cervix and uterine corpus), survival is more favorable than for those occurring most frequently in men (lungs, prostate, colon and bladder). In addition, for most cancer sites common to men and women, survival rates are higher for women.

Surgery is the most used form of treatment. During the 10-year period 1955-64, 55% of all patients were treated by surgery, 29% by radiation and 18% by chemotherapy. Although surgery has remained the treatment of choice in recent years, more patients are receiving radiotherapy (34%) and chemotherapy (22%).

Early detection, while the cancer is localized or limited to the organ of origin, offers the best opportunity for control. There has been an encouraging increase in the proportion of cancers of the breast, prostate, bladder and brain and melanoma of the skin being diagnosed while localized. The percentage of breast cancers localized at diagnosis has increased from 38% to 47% in the past 20 years; for prostatic cancer, the percentage localized has increased from 49% to 63% in the same period.



## From The Journal 50 Years Ago

Please do not gather from what Dr. Pfaff has said that all vomiting babies have pyloric stenosis, and please if you do suspect pyloric stenosis do not take them off the breast. In so doing you have lost the best therapeutic agent for recovery that you have had, that is, the best therapeutic agent after the operation. Every baby spits up more or less. That is not vomiting. In the pyloric stenosis cases the vomiting is of the projectile type, as Dr. Pfaff stated, and the youngster frequently throws food three or four feet. Ordinary vomiting is due to over-feeding and can easily be corrected by reducing the time of nourishment or the amount of food which is given if he is on artificial diet. If you suspect stenosis in any given case I would strongly advise that you take the time to see the baby fed and that you see it fed when it is stripped. You cannot diagnose pyloric stenosis with two or three layers of napkin, a shirt and a dress. If you feed the baby and then watch the abdomen you will see the waves. The men who have written the most about this subject tell you that you can feel the tumor itself in every instance. I do not believe this is true. You may find the tumor mass if you look long enough.

The constipation that is associated with pyloric stenosis is very marked. It indicates the decreased amount of food that is going through and that is one of the important points of the diagnosis. It has been my pleasure to see nine cases, one of which may have been a pylorospasm. Seven of these cases were operated upon and five of them are alive.—James C. Carter, M.D., Indianapolis, Discussion before Surgical Section at the 1922 ISMA Annual Meeting, **JISMA** Nov. 1922.



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Available:  
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#### Android-HP

HIGH POTENCY

Each red tablet contains:  
Methyl Testosterone . . .5.0 mg.  
Thyroid Ext. (1/2 gr.) . .30 mg.  
Glutamic Acid . . . . .50 mg.  
Thiamine HCL . . . . .10 mg.

Dose: 1 tablet 3 times daily.  
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EXTRA HIGH POTENCY

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Methyl Testosterone . .12.5 mg.  
Thyroid Ext. (1 gr.) . . .64 mg.  
Glutamic Acid . . . . .50 mg.  
Thiamine HCL . . . . .10 mg.

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Thiamine HCL . . . . .25 mg.  
Glutamic Acid . . . . .100 mg.  
Pyridoxine HCL . . . . .5 mg.  
Niacinamide . . . . .75 mg.  
Calcium Pantothenate .10 mg.  
Vitamin B-12 . . . . .2.5 mcg.  
Riboflavin . . . . .5 mg.

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Available: Bottles of 60, 500.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug products useful in treatment involving concomitant use of two or more drugs?**

**Opinion**

**Results of a questionnaire to 7,000 physicians:**

**62.9%**

**Believe combination drug products are useful.**

**13.8%**

**Do not believe combination drug products are useful.**

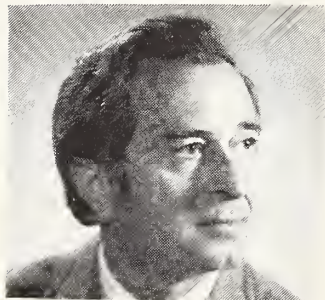


# Are combination drug products useful in treatment involving concomitant use of two or more drugs

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years that have an apparently satisfactory track record.

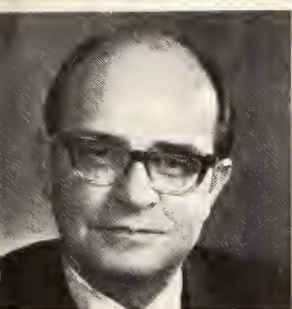
For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosing errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA should play a major role in making this determination. In fact, I don't think it is avoid taking the ultimate responsibility, but it should enlist the help of outstanding physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

W. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" denies the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the worst of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational. Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

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Primary tuberculosis of skin—diagnosis  
and treatment.

### *Primary Cutaneous Mycobacteriosis*

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South Bend

RICHARD GOLDYN, M.D.\*\*  
Fort Wayne

ROBERT DENHAM, M.D.†  
South Bend

**I**NFECTIONS of the skin, lymph glands, and soft tissues by the tubercle bacillus occur with sufficient infrequency as to merit added emphasis in the differential diagnosis of "chronic cutaneous lesions."<sup>10</sup> In spite of their relatively more frequent occurrence in children,<sup>1</sup> those disorders can nevertheless be found in all other age groups as well, without additional discrimination for sex, occupation, exposure, or climate alterations.

This case is presented in an effort to re-emphasize the variable manifestations and complaints of patients with "primary inoculation mycobac-

teriosis," particularly with regard to securing an adequate history prior to treating even relatively minor skin lesions.<sup>11,12</sup>

#### Case Report

The patient is a 23-year-old white female who initially complained to her family physician on November 18, 1968, that she had difficulty with pain, swelling and redness, in the distal part of the right fourth digit. She stated that she had injured it, presumably, about a week earlier. Her supervisor had taken a culture; and the report was that of a "group D Streptococcus."

Past history revealed only that she worked as a technician in microbiology at a local laboratory and that she had dropped a culture tube a few days prior to the development of the lesion. She could not remember specifically cutting herself on the broken glass. The tube was a culture for acid fast bacilli.

Physical examination was negative except for some non-tender cer-

vical lymphadenopathy in the posterior chain — particularly on the right side — as well as a small node in the right epitrochlear area; and mild posterior pharyngeal injection with a vesicular enanthem. The small ulcerated lesion was located on the palmar side of the finger; and was inflamed adjacently. There was a moderate amount of crusted material at the site of the slightly raised and swollen tip of the fourth digit.

A BUN, CBC, and two hour post-prandial blood sugar were within normal limits. She was treated with 600,000 units of procaine Penicillin G IM and placed on phenoxymethyl penicillin 250 mgs q 6 hours for five days, p/o. Thereafter, when she was examined on November 26th, healing had progressed rather satisfactorily.

When next seen, on February 24, 1969, we noted that there was a rather prominent cicatricial reaction at the site of her previous injury; and there were now two large

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### Results of Skin Tests

1. PPD-S	(positive)	17 mm diameter
2. Photochromogenic*	(positive)	15 mm diameter
3. Scotochromogenic*	(negative)	0 mm induration
4. Non-Chromogenic*	(positive/neg.)	8 mm diameter

groups of matted, and tender, nodes at the epitrochlear and axillary areas of her right arm. The nodes were approximately 3 cm in diameter and 2 cm in length; she could not adduct her arm completely to the side. She also complained of sensations of warmth, diaphoresis, and rigours without significant weight loss. Further physical exam was negative on that occasion.

A chest x-ray was unrevealing; white count was 7,600 with 69 segmented neutrophils, 5 non-segmented neutrophils, 21 lymphocytes, 2 eosinophils and 3 monocytes; the hemoglobin was 13.0 gms percent; the total protein was 7.5 gms with an albumin of 4.2 gms percent; and an SGOT of 20 Karmen units. The Sed Rate was 32 mm/hour (corrected).

Skin tests — including a PPD-S, Scotochromogen; Photochromogen and non-Chromogen—were applied. The patient was referred to an orthopedic surgeon, and a biopsy was obtained from the matted epitrochlear nodes, which were “tender and firm,” according to his notes of March 3, 1969; stains and cultures were then obtained, on the material resected. By April 10, 1969, corroborative evidence from the laboratory was received confirming the presence of a growth of *Mycobacterium tuberculosis* (variety *hominis*) on the basis of the initial culture; it should be noted that several acid fast bacilli were noted on the Ziehl-Neelson stain from the smear

taken at the time of the biopsy.

A diagnosis of inoculation tuberculosis with lymphadenitis was made and treatment instituted with INH and Streptomycin for six weeks; and the INH alone for another ten months. However, because of the continued discomfort and slow resolution of the axillary adenopathy, surgical excision was accomplished. There was, however, no active draining ulcer, no evidence of an inflammatory response, and no abnormal systemic reaction.

Since that time the patient has been asymptomatic, and has had negative serial chest x-rays, as well as blood counts, with no evident recurrence of the “primary” lesion and its associated adenopathy.

In this particular subject, the prior skin tests obtained annually had been negative, with the PPD-S; and her chest x-rays had shown no evidence of previous disease.

### Discussion

Primary (cutaneous) inoculation mycobacteriosis elicits a reaction in the host which is entirely analogous to that of “first infection” pulmonary tuberculosis.

It has been noted previously that the primary complex consists of the initial cutaneous reaction at the site of inoculation, plus the associated regional lymphadenopathy.<sup>4</sup> The “latency period” following a traumatic lesion has been quite variable, but from 1-3 weeks may elapse before evidence of the disease is detectable. During that interval, there is a non-specific tissue reaction at the site; it consists of a slow-healing, indolent type ulcer (on occasion,

with a superimposed pyogenic infection, as in our case). No singular characteristic of the lesion per se would lead one to suspect a specific etiologic agent — with the possible exception of a carefully conducted historical review. Thereafter, however, usually during the third week, significant regional adenopathy follows the lymphatic drainage from the site of the initial lesion. The entire process requires a break in the protective skin barrier, since that particular organ of the body represents a rather resistant one for invasion by the tubercle bacillus.<sup>6</sup>

Although relatively unusual, there have been increasingly frequent reports, in the recent literature, of infection involving the cervical lymph glands, particularly in children and young adults, due to the “atypical mycobacteria” — more specifically, the Scotochromogenic acid fast bacilli (it should be noted that in this patient the Scotochromogenic skin test was negative).<sup>14</sup> In addition, of course, other mycobacteria such as *M. balnei* and *M. ulcerans* could produce lesions of this variety, particularly because of the decreased skin temperature at the site of her lesion.<sup>16</sup> However, culture reports were “classic” for *Mycobacterium tuberculosis* (variety *hominis*).

This histologic appearance of an early reaction in the skin is that of a non-specific infiltration with polys, and mononuclear cells. At that stage, organisms may be found in profuse numbers within the lesion; with the classic variety of *Mycobacterium tuberculosis* (variety *hominis*) being the chief isolate.<sup>2,3,8</sup> Then, at three to six weeks, the epithelioid containing giant cells evolve in the upper and middle layers of the dermis, as well as in the regional and more distant lymph nodes draining the site; at that stage caseation necrosis would appear to be the most specific microscopic finding.<sup>4</sup>

\* The antigens were supplied to us through the courtesy of Dr. John S. Chapman, Professor of Medicine at the University of Texas, Southwestern Medical School in Dallas.



With regard to the skin test reaction for tuberculosis, there are variable periods which have been quoted; but it would seem that during an interval of 2-6 weeks after initial contact a positive might be anticipated in 60-90% of the cases.<sup>7</sup> (However, even more recent reports<sup>17</sup> may alter those percentages downward.)

It is quite apparent when one views the entire spectrum of tuberculosis, including all other varieties of extra-pulmonary tuberculosis, that the primary types of cutaneous infections are in the minority.<sup>5,9,13,16</sup>

A specific diagnosis, then, consists of utilizing a composite of clinical and laboratory information including an adequate history; careful physical examination, baseline inflammatory laboratory determinants, a direct smear from the lesion (if draining), and finally a biopsy, with subsequent culture-growth of "classical" tubercle bacilli. Other criteria would include a response to therapy and conversion of a known "negative" skin test reactor to a positive — in conjunction with the continuing presence of a negative chest x-ray.

Differentially, or on initial examination, the rather nondescript nature of the lesion could easily cause one to confuse it with such entities as a pyogenic ulceration and associated bubo, epitheliomas with metastases to regional nodes, a luetic chancre, sporotrichosis, "cat-scratch fever"; and cutaneous tularemia.

With regard to therapy, we have evolved from an initial stage of surgical treatment — following hot soaks and the application of aseptic materials to a second level utilizing radio therapy in a topically directed form. Too frequently, however, recurrences, or chronic draining lesions, were detected. With the advent of more specific anti-microbial drug therapy, a third level of treatment has been developed for man-

aging this disorder. It has been our experience that utilizing a program including INH in a dose of 5 mgms/Kilo/24 hours for a period of one year, plus Streptomycin for the first 6 weeks, offers the most satisfactory form of therapy. In certain instances where regional, or satellite, nodes have become "matted" and do not respond with a reduction in size — permitting better mobilization — surgical extirpation can be effectively accomplished after a period of three months on drug therapy.

### Summary

In summary, we have detailed a case of primary cutaneous tuberculosis occurring in a laboratory technician. The specific presentation was unusual in that the lesion had initially responded to conventional therapy; but the subject returned several months later with a healed "primary lesion," then associated with rather malignant-appearing nodes in the epitrochlear and axillary areas of the involved arm. The emphasis should quite logically be directed toward the importance of an adequate history prior to treatment, as well as continued awareness of the multiplicity of presenting forms for active tuberculosis.

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# The Cooper Quiz\*

## "Self Assessment"

### The New England Journal of Medicine, April 6, 1972

1. Alcoholism and cirrhosis increase host susceptibility to infections. Nutritional and mechanical factors seem to be fully responsible. TRUE or FALSE
2. A man with "tertiary" hyperparathyroidism and vitamin D-resistant rickets was apparently "cured" by removal of an unclassified mesenchymal tumor of the pharynx. It must be implied that the tumor was secreting a vitamin D antagonist. TRUE or FALSE
3. Newborn infants who suffer from heroin-withdrawal symptoms have                      respiratory rate.  
(a) increased    (b) decreased
4. The respiratory-distress syndrome in newborn infants with heroin-withdrawal symptoms is common. TRUE or FALSE
5. Fifty percent of the liver's productive activity is the production of serum albumen. TRUE or FALSE

### The New England Journal of Medicine, April 13, 1972

6. Bone marrow transplantation in Swiss-type agammaglobulinemia may have varying degrees of graft-versus-host reactions. If the transplant is from an HL-A identical sibling the reaction is non-fatal and self limited. TRUE or FALSE
7. The Marfan syndrome while causing considerable morbidity is not a life-shortening disease. TRUE or FALSE

8. The great majority of cases of Marfan syndrome are familial. About                      percent of cases are the result of new mutation.  
(a) 5                      (c) 15  
(b) 10                      (d) 25
9. There are no drugs that will decrease the aortic weakness and/or dissection in Marfan's syndrome. TRUE or FALSE
10. Epsilon aminocaproic acid is better than ephedrine and antihistamines in the treatment of hereditary angioneurotic edema. TRUE or FALSE
11. Codeine (65 mg) is a much more effective analgesic than aspirin (650 mg). TRUE or FALSE

### The New England Journal of Medicine, April 20, 1972

12. The *degree* of pulmonary emphysema is no greater among smokers than non-smokers. (Please note "degree" not "incidence".) TRUE or FALSE
13. In cases of intrahepatic biliary atresia, phenobarbital will reduce the itching but it increases the jaundice. TRUE or FALSE
14. In patients with hypertension, good blood pressure control depends on maintenance of reduced blood volume. TRUE or FALSE
15. A Danish study screened 13,300 blood donors for Australian-antigenemia. It was found that the absence of post-transfusion hepatitis in the recipi-

ents was probably related to the absence of hepatitis in the donors. TRUE or FALSE

### The New England Journal of Medicine, April 27, 1972

16. In a recent Harvard study an index, determined through multiple discriminant analysis of the usual tests for coronary insufficiency plus coronary cinearteriography, was developed. With the combined use of all of these diagnostic tools the index became quite accurate for obstructive coronary-artery disease. TRUE or FALSE
17. Patients with systemic lupus who have antibodies to a RNA-protein antigen and a low frequency of complement-fixing antibodies to ssDNA have a low frequency of serious renal disease. TRUE or FALSE
18. Patients who have chronic obstructive lung disease due to emphysema are more apt to have pulmonary hypertension than are patients whose lung disease is due to chronic bronchitis. TRUE or FALSE
19. Euthyroid people produce approximately (1)                      micrograms of thyroxine and (2)                      micrograms of tri-iodothyronine daily.  
(a) 80                      (b) 50
20. "Cold" thyroid nodules contain primarily  
(a) cells                      (b) colloid

Answers may be found on page 1205.



# Changing Physician Involvement in Obstetrical Care in Indiana, 1940-1969\*

JAMES E. CARTER, M.D.  
JEFFREY CAIN, M.D.  
Indianapolis\*\*

IN 1969 a Maternal Care Committee of the Indiana Obstetrical and Gynecological Society was formed to study the delivery of obstetrical care in Indiana.

The objectives were to determine (1) Who performed the obstetrical care in Indiana (type of practice, age, area of interest), amount of individual involvement (number of deliveries performed per year), and is there a change from 1940 to 1969? (2) Where are the deliveries performed, Urban—Rural, 1940-

\*Supported by a grant from the Indiana State Board of Health, Division of Planning and Evaluation-Use in comprehensive health planning in Indiana.

\*\*From the Indiana University School of Medicine, Department of Obstetrics & Gynecology, Indianapolis 46202.

1969? (3) What is the attitude of the physician concerning the obstetrical care in the state?

### Method

Fifty-five thousand five hundred and sixty-two (55,562) birth certificates in the month of October in the years 1940, 1945, 1950, 1955, 1960, 1965, and 1969 were reviewed. The information was placed on IBM cards and programmed for a 7040 IBM computer. An attitudinal questionnaire was developed and sent to physicians performing obstetrical care in the state. Sixteen hundred questionnaires were sent out and 1,192 (75%) were returned.

### Results

#### *Birth Certificate Survey*

The number of births occurring in

Indiana from 1940 to 1969 is seen in Figure 1. The estimated number of births from 1970 to 1985 is based on the projected variables of the birth rate and fertility rate, also seen in Figure 1.

The number of physicians performing obstetrical care is seen in Figure 2. Since 1950, the number of physicians performing obstetrical care is steadily decreasing, with a loss of 800 physicians doing obstetrical care in the past four years. The figures for 1985 reflect the number of physicians that would be necessary to provide care as it was provided in 1969 (see comment).

Figure 3 shows the number of deliveries per attendant. Since 1940

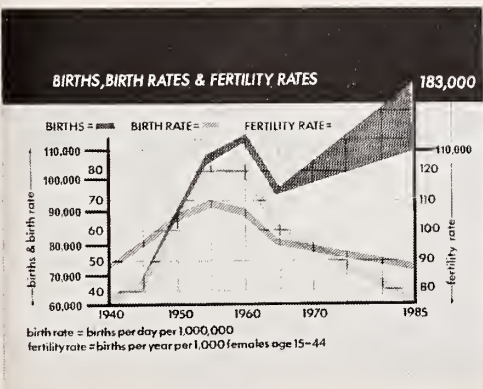


FIGURE 1

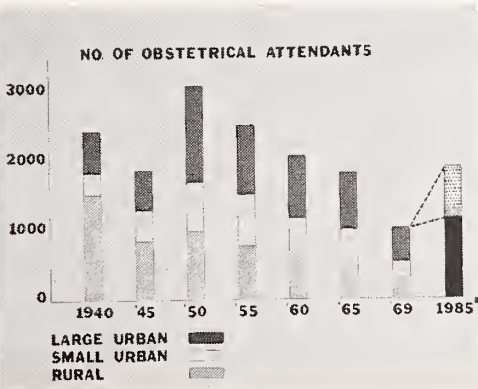


FIGURE 2

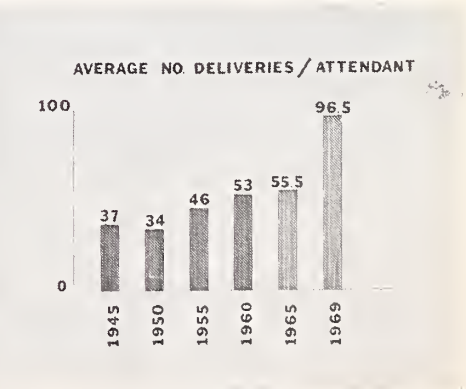


FIGURE 3



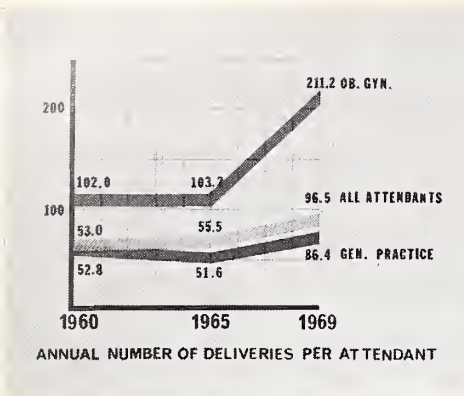


FIGURE 4

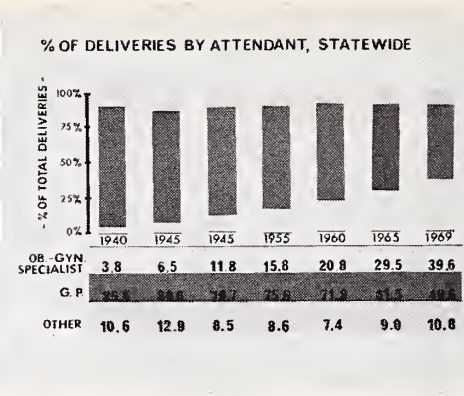


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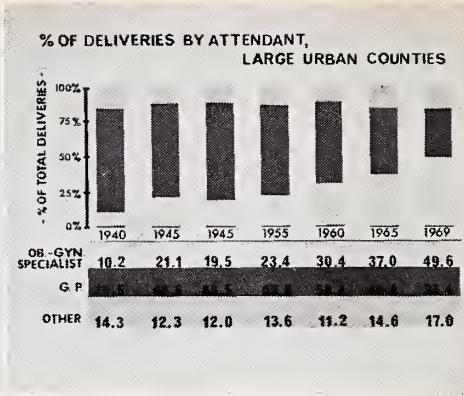


FIGURE 6

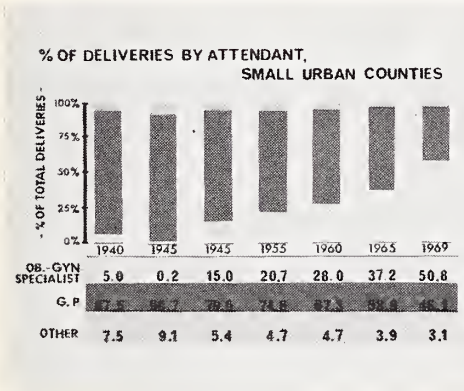


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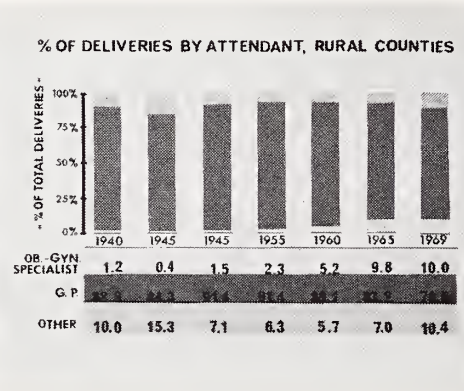


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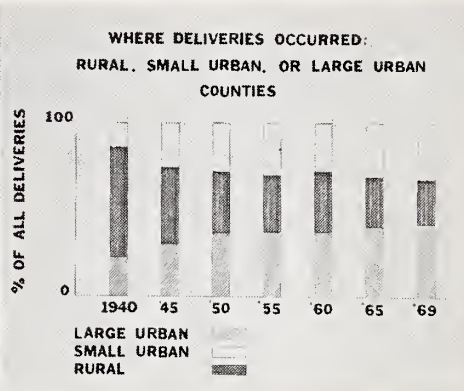


FIGURE 9

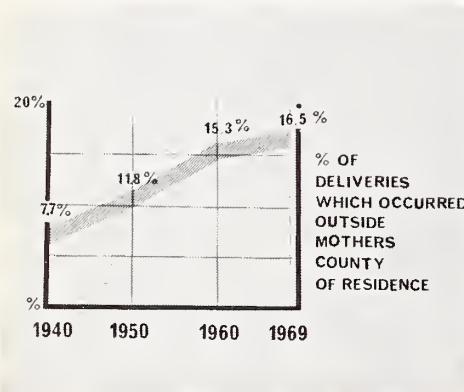


FIGURE 10

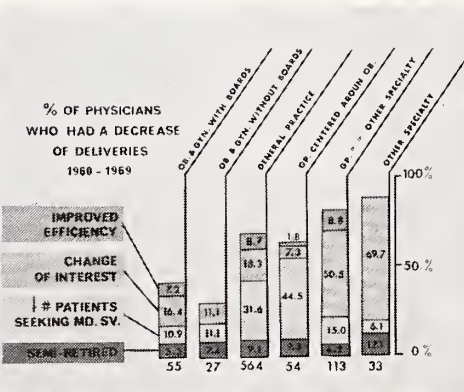


FIGURE 11

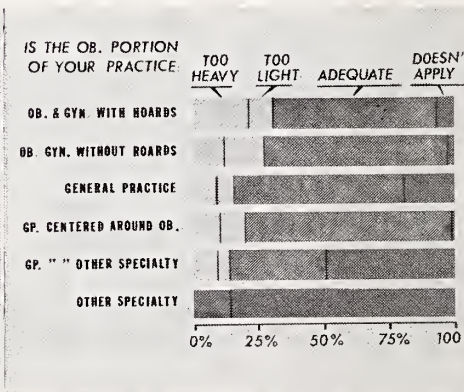


FIGURE 12

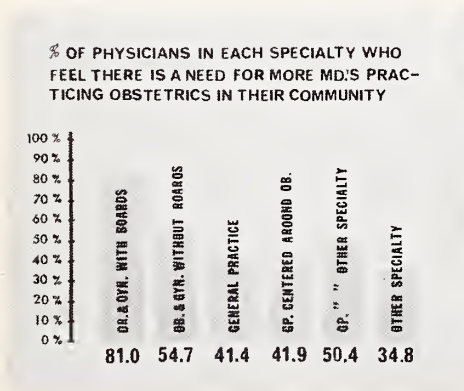


FIGURE 13

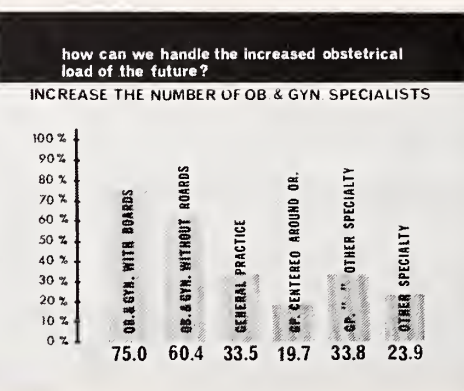


FIGURE 14

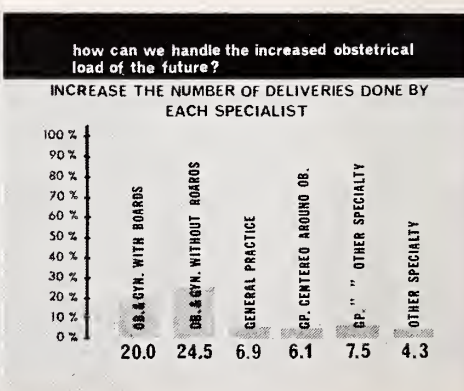


FIGURE 15



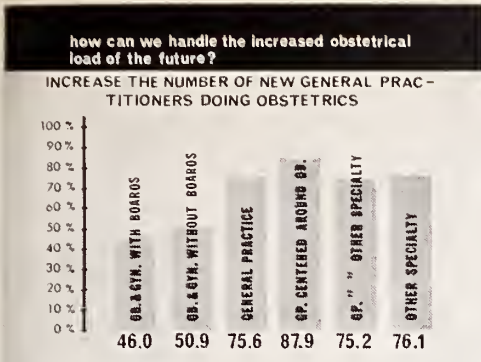


FIGURE 16

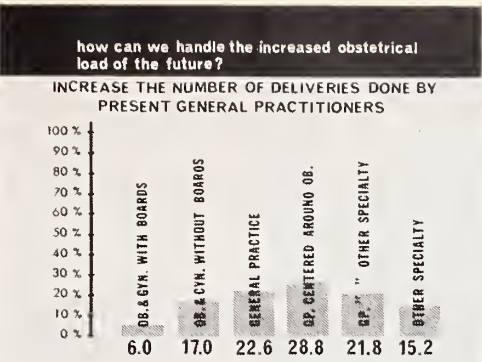


FIGURE 17

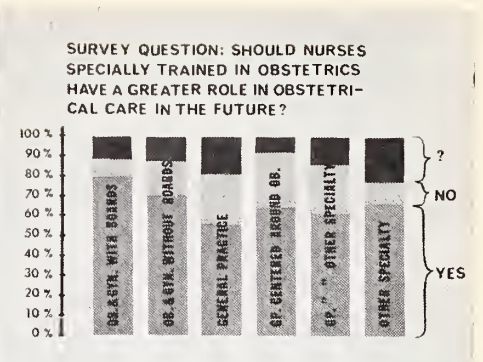


FIGURE 18

this is increasing. Figure 4 shows the number of deliveries per attendant according to the type of practice. Deliveries performed by the specialist have doubled in the last four years.

Figure 5 shows the percentage of all deliveries performed by the general practitioner and the percentage performed by the specialist from 1940 to 1969, in the state of Indiana. Figures 6, 7, and 8 show the percentage of all deliveries performed by the general practitioner and specialist in large urban, small urban, and rural areas respectively. The large urban counties represent populations of more than 250,000; small urban, 50,000 to 250,000; and rural, less than 50,000.

To determine where the deliveries are performed, the 92 counties of Indiana, classified again according to large urban, small urban, and rural counties, were studied. An increase from 1940 to 1969 of the large and small urban deliveries and a decrease in the rural county deliveries is seen in Figure 9. This shift is due to a population shift of the place of residence and also, as can be seen in Figure 10, by a shift from the county of residence to a different county for the place of delivery.

### Attitudinal Survey

Figure 11 shows the percentage of physicians that had a decrease in their obstetrical practice in the past 10 years. The two common reasons given for this decrease are (1) a reorganization of practice to improve efficiency or personal interest and (2) a decreasing number of women seeking the physicians' services.

Figure 12 shows an expression of the physician's impression, quantitatively, of his obstetrical care involvement.

The physician's opinion whether more physicians were needed in his community to practice obstetrics is seen in Figure 13, according to the type of practice of the physician.

The physicians were asked about possible solutions to the increasing number of births anticipated in the state of Indiana. Figure 14 shows those physicians who felt that more specialists are needed. Figure 15 shows those physicians who recommended an increase in the number of deliveries performed per specialist. Figure 16 shows those physicians who recommended an increase in the number of general practitioners doing obstetrics. Fig-

ure 17 shows those physicians who recommended an increase in the number of deliveries performed per general practitioner.

Figure 18 shows the physician's attitude concerning the acceptability of utilizing specially trained nurses in obstetrics.

### Comment

In 1940, more than 90% of Indiana physicians were involved in obstetrical care; in 1969, less than 25% were involved. It would appear that if the current trends of physician involvement continues, an increasingly stressful situation may occur. The attitudinal questionnaire shows many physicians already feel that their obstetrical care involvement is too heavy.

If the current trend should level off and physician involvement remain as it now exists, to care for 110,000 births in 1985, we will need to add 4-6 new obstetrical specialists per year and 25 new family practitioners per year. If the number of births should increase to 183,000 births by 1985, we will need 6-7 new obstetrical specialists added per year and 44 new family practitioners added per year. ◀

### Erratum

The Journal belatedly acknowledges the assistance of Mrs. Helen L. Davidson, head archivist at Eli Lilly and Company, in the preparation of the article on insulin which appeared in the August issue under the title "The Miracle Workers." Her help was invaluable, and The Journal apologizes for its failure to mention its indebtedness to her.



# Reminiscences of a Country Doctor

GLADYS RALPHY WHITAKER  
Nashville

**D**R. Alfred J. Ralphy was born March 28, 1854, in Nashville, Brown County, Indiana. He was the youngest of three children, Emma, James and Alfred, of John and Sarah Jones Ralphy, who were natives of England. His father was born in London in 1797 and died in 1886; his mother was born in Warwickshire in 1817. She died April 28, 1876. Both are buried in Greenlawn Cemetery at Nashville.

The father was a soldier in the British army, a shipbuilder, a skilled architect and carpenter. He organized a Mechanics' Relief and Aid Association there. At that time all the ornate decorations on buildings were made by hand and he brought two sea chests full of carpenter's tools to America with him for making these things.

In 1846 the family, with a group of other people from England, emigrated to South America to form a colony, but they became dissatisfied there and decided to come to the United States. On account of the Mexican War, which was in progress, they had to leave (Venezuela) by night and land at New Orleans at night. They first went to Cincinnati, Ohio, and remained there until 1853 when they moved to Brown County, leaving his three children by a former marriage in Cincinnati. They were grown and had families of their own.

Alfred was born and reared in Nashville and, at the age of 12, got a job at the printing office, where he worked between terms of school until he began teaching school at the age of 16. (I have been told that

teachers at that time received \$1.00 for each pupil for the entire term of school!)

The terms of school were short, and one year, after he had completed one term in the vicinity of Nashville, there was a vacancy in the school at Story, due to the fact that a group of the older boys had "run the teacher out." He got the job of finishing the term there, which he did successfully. He walked from Nashville, at least on week ends, a distance of 8 or 10 miles over Weed Patch Hill, now the Brown County State Park. Later, some of those boys who went to school to him there, with their families, became his medical patients.

Between school terms and in any free time he had, he clerked in a drugstore. His experience there and the knowledge he gained in handling medicines became a great asset to him later in his chosen profession.

At this time he also began "reading medicine" in the office of his brother-in-law, Dr. Arnold S. Griffith. This was the customary education of physicians at that time and many of them received no further training. He, however, formed a partnership with Dr. Griffith for a year before establishing his own office. I do not know the exact date when Dr. Ralphy started practicing medicine but it was early in the 1870s.

In 1878 he graduated from the Cincinnati School of Medicine and Surgery and later, in 1884, he graduated from the Kentucky School of Medicine in Louisville, Ky.

At this time the roads of Brown County were little more than bridle paths through the forest and everyone went on horseback. I remember being told of Dr. Ralphy getting so cold and so nearly frozen that, when he reached the patient's cabin, he had to be taken off his horse and warmed up before he could minister to the sick patient.

He carried the medicines in a saddle bag which was so made that there were two compartments in which small bottles of tablets were held, each in its own holder, and a wide strip of leather between them which was placed across the horse's back just in front of the saddle. People said Dr. Ralphy thought he was in heaven when he got his first two-wheeled cart that had a seat between two large wheels and was built up in front so there was a place to rest his feet. Of course, it was pulled by a horse.

He was a great lover of nature and no rare bird, flower, rock or tree escaped his notice. Here I quote from an article written by Anton Scherrer, columnist for the Indianapolis Times, who wrote about a Mr. Cottman who had written about a trip to Brown County and of the things of interest he found there.

"Mr. Cottman's greatest discovery, however, was Dr. A. J. Ralphy, a country physician in Nashville. 'On the side,' said Mr. Cottman. 'Dr. Ralphy was a naturalist, taxidermist, collector and all-around scientist. His office looked like an aviary with its hundred or more Brown County birds all of his own



mounting. He also had a cabinet of insects indigenous to the region and quite a surprising collection of precious stones, small but genuine, such as opals, garnets, rubies and one diamond. All of them had been gathered from the creek beds of the county.' ”

He maintained his interest in nature throughout his life. If anyone found an Indian relic (he had a nice collection of them) or saw a rare bird, he brought it to “Doc” as everyone called him. His prize possession, however, was a Golden Eagle which someone killed on Weed Patch Hill (now Brown County State Park) and brought to him. It was a beautiful bird with a 6-foot wing span, which he mounted with its wings spread, and to this day it “stands guard” in his office.

On June 12, 1878, he was united in marriage to Adeline Keller, also of Nashville, a daughter of Michael and Kathryn Keller, who were natives of Germany. She was of sterling character and of great assistance to him for all the 50 years of their married life. To this union were born five children, a son who died in infancy, another son Clifford who taught school as a stepping stone to Business College and was for many years secretary and treasurer of the



THIS PHOTO of the Ralphy family was taken in 1911 and the author is the pretty young lady with the big hairbow. From left to right are: Gladys Ralphy (Whitaker), Eva Ralphy (Brown), Grace Ralphy (Campbell), Clifford Ralphy, and their parents, Dr. and Mrs. A. J. Ralphy.

F. E. Gates Marble and Tile Co. of Indianapolis. Also born were three daughters, Grace, Eva and Gladys. The latter two became teachers in the schools of Brown County. Grace also was educated to be a teacher but, since she was very frail, she felt she could not cope with teaching conditions as they were then and she never taught school.

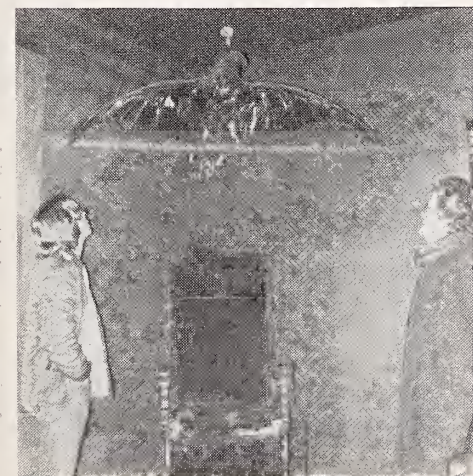
In addition to their own family, they reared and educated an orphan niece of Mrs. Ralphy, Alpha Taggart. In fact, Mrs. Ralphy gave up working in Terre Haute about a year before she was married to come home and take care of this baby when the mother, her sister Julia, died. I have been told that when they went to church, Dr. Ralphy would carry this infant to church as if she were their own. Then, when they were married, of course the baby became a member of the new household. They educated her to be a teacher and she lived with them until she was married to Isaac Evans.

#### Medical Society Organized in 1879

While in Nashville, Dr. Ralphy helped organize, and was secretary of, the Brown County Medical Society, which was organized October 23, 1879 in Nashville.

The object of the society, as stated in the constitution adopted, was “to provide an organization through which the regular physicians of the county may be united in one professional fraternity for the purpose of giving frequent expressions of the views and aims of the medical profession; to supply more efficient means for the cultivating and advancing medical knowledge; for elevating the standards of medical education; for promoting the usefulness, honor and interests of the medical profession and encouraging emulation and concert of action among its members; for facilitating and fostering friendly intercourse between those engaged in it; for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men; and for the promotion of all measures adopted for the relief of the suffering and to improve the health and protect the lives of the community.”

A two-thirds vote of the membership was required for election to the society. The ethics of the American Medical Association were adopted for the regulation of the organization. A seal was adopted, bearing the legend in Roman letters,



THE GOLDEN EAGLE which Dr. A. J. Ralphy mounted is shown here with the doctor's examining chair in the background. Robert Evans, a grandson of Alpha Taggart, and Mrs. Whitaker are admiring the eagle. A 1971 photograph.





THE FAMILY HOME at New Bellsville, in southwestern Brown County, from a photo taken about 1911.

"Brown County Medical Society, organized October 23, 1879," and within the center a mortar and pestle.

Initially, there was great interest and regular meetings. In the Proceedings of the Indiana State Medical Association, Brown County Medical Society was first listed in 1880 and appeared yearly until 1883, when the Medical Society became inactive. The following were members of the Medical Society:

J. M. Cook, Nashville, president; Richard E. Holder, New Bellsville, vice president; A. J. Ralphy, Nashville, secretary (at least one year he was treasurer); Nathan Brown-ing, Elkinsville, treasurer.

## 20 Physician Members

Other members were:

Enoch S. Arwine, Bean Blossom  
William H. Beatty, Needmore  
William H. Banks, Waymansville  
H. C. Connor, Nashville  
James B. Campbell, Bean Blossom  
Marian A. Duncan, Nashville  
John F. Genolin, Nashville  
John H. Leonard, Elkinsville  
James P. Moser, Spearsville  
A. C. Spencer, Bean Blossom  
P. E. Smith, South Bethany  
A. A. Cook, Bean Blossom  
Capt. T. Taggart, Nashville  
James G. Ward, Bean Blossom  
T. E. Warring, Nashville  
A. J. Wright, Bean Blossom

Practitioners not associated with the Society:

Joseph N. Fleener, Needmore  
Arnold S. Griffith, Nashville  
N. L. Judah, Bloomington  
Stephen Mossop, Schooner  
W. H. Roddy, Mt. Moriah  
George P. Story, Pikes Peak  
Samuel Wilson, Pikes Peak  
John M. Warring, Smithville

Midwives practicing in 1880:

Lavinia Hatchet, Schooner Valley  
Sarah M. Merryman, Ramilton  
Joannah Richards, Richard  
Marietta Smith, Bloomington  
Amy Whitehorn, Pikes Peak

I have been told that when Dr. Ralphy was at Nashville he kept two drivers and two teams busy taking him on calls night and day. During the busy season, what little rest he got was during these trips when the driver was driving the horses.

Dr. Ralphy was a charter member of the Knights of Pythias and became a member of the Masonic Order in 1882. The following is quoted from the secretary's record of the Masonic Lodge of Nashville, F. and A.M.

"His petition for membership was presented to the lodge, Dec. 31, 1881. The investigating committee appointed was R. L. Coffey, E. Hamblen and W. L. Cox. He was elected and received the Entered Apprentice degree Jan. 28, 1882; received Fellowcraft degree March 4, 1882, and received the Master Mason degree April 1, 1882. On Dec. 23, 1882, he was elected to the office of Junior Warden; Dec.

8, 1883, was elected Senior Warden and also Senior Warden Nov 29, 1884, and elected Worshipful Master Dec. 19, 1885, which office he held in 1886."

He was elected coroner of Brown County several terms and secretary of the Board of Health several terms. He was on the board of pension examiners for the Civil War veterans and also for those of World War I. He was later a charter member of Horricon Tribe of the Order of Red Men of New Bellsville.

In 1891, the family moved to New Bellsville which in those days was a day's journey from Nashville. The first year they lived in a small house across the road from the Baptist Church where they attended services and later all the family became members of that church. It was in that house that Eva was born.

In 1892 they purchased the house, a beautiful place surrounded by trees and beautiful flowers they all loved so much and where they spent the remainder of their lives. In that house, I (Gladys) was born.

For the rest of my story I shall have to rely on my memory of things that transpired, for there is no written record that I know of and most of the people who had the record written in their hearts are gone.

First, let me say that Dr. Ralphy didn't receive much money for his services. He charged only \$1.00 for making a trip of three miles to Stone Head and back and issued medicines also. When people along the way found out he was going past, they would have him stop at their house—at no extra charge, of course.

Money was scarce and many of the people had a difficult time feeding their families which, in many instances, were large, and they had to depend on farming poor soil for their living. He was on call 24 hours every day, and, as most physicians of that day, he accepted anything he could use in lieu of money. Most



of his patients were of farm families and paid with corn and hay for the horses, pork or beef, some mutton (sheep) and occasionally some farmer would butcher a goat and share it "on the bill." Others who had orchards brought apples, pears or peaches (usually small but well flavored). Others paid with wood, which everybody used for fuel then. Some would plow the garden, paint the house or office or perhaps do paperhanging or carpentering if needed. We had a large lawn with many apple trees and shade trees and I remember one boy raked leaves in the fall to pay on his family's bill.

But it didn't matter whether he got any pay or not, nor if he knew he wouldn't get paid at all; if anybody needed him, he would go night or day.

If it could be said he specialized in any one branch of medicine, it was obstetrics. He was often called by younger doctors in the surrounding area for consultation in such cases. They would express surprise that he had kept up to date so well. I think he did this by carefully studying the good medical journals which he took by mail and by reading up-to-date medical books. He brought 1,936 babies (possibly more) into this world and not one mother lost her life in childbirth and very few of the babies were lost. Remember, these people often lived in poorly lighted cabins. Some of them lived in good houses but *all* had only oil (kerosene) lamps and it seemed most of these cases happened at night! If he expected a "difficult case," he took Mother with him to assist him, for he knew she was steady, courageous and dependable in any crisis and would and could help under any circumstances.

He charged only \$5.00 for delivering a baby or \$10.00 if it was a difficult case which required the use of instruments. Much of this

was never paid. I remember one bad night he was called and the man said "Doc, your money is waitin' for you." He only got 50¢ that time.

I remember one time a man got his hand badly shot and an amputation was necessary. As usual, Mother was there to help and held the hand while Father performed the surgery. Some of the onlookers said "Mrs. Ralphy must be awful hard-hearted to do that." She was sympathetic and kind and did not like to do it, but there was no one else that could be depended upon, so she had to do it. There were no hospitals near enough to which to send the seriously ill or injured.

In 1902, telephones came to that section of the country and the switchboard was put in our house. It paid a meager sum but the great advantage was that there was always someone, usually Grace, there to take calls for the doctor. In many ways the telephone was a big help but people would invariably call at night. A lot of times Dr Ralphy knew he would get no pay but he always said "The poor fellow would pay if he could," and he would go.

### **Lost No Patients in Flu Epidemic**

It was especially hard during the influenza epidemic of 1918. He had two cases of pneumonia on hand, besides the many, many cases of flu, but he brought them all through it safely, even tho in other communities many people died. Although the doctor didn't actually have the flu himself, the constant strain on him weakened him for the rest of his life.

Going back to the earlier days, he had a faithful little dog, a brown, curlyhaired water spaniel, Prince, who would go with him in the buggy and lie on his feet and kept them from freezing. Later, he got a foot-warmer which used hot charcoal and did a fairly good job.

I recall many times when, as a child, I would go with Father on

calls that were not expected to be too long. I stayed in the buggy, but if there were children there, I would play with them. Mother always kept my little white sunbonnet and a white pinafore all washed and starched and ironed, as only she could iron them, so I could go whenever the opportunity came. Years afterward, people would tell me they remembered the little white sunbonnet I used to wear.

It was on these trips that Father taught me to love birds and to recognize the different species and their songs (although I never mastered the songs very well) and he pointed out the wild flowers that grew along the road. He even let me "drive" the horses sometimes. They didn't need much driving, since they knew where his patients lived, and they would stop there without any assistance from me.

But disaster struck a cruel blow on the night of Jan. 19, 1907. He had to make a call to Christiansburg that afternoon. There were no bridges over the creeks and it had been raining. When he came back that night, he had to cross the creek near Pikes Peak which had been all right in the afternoon, but when he got about half-way across the creek, he saw what looked like a wall of water coming down the creek. Before he could get across, the water turned the buggy over, put out the lanterns on the buggy, threw him into the icy water, threw the older horse over the other one and tangled the harness until, try as he would to save the horses, he had to give it up.

He knew how to tread water, which saved his life. He was in the icy water until he came to a cabin about a mile down the creek where he was taken in and dried out, but the poor horses, which were like members of the family, were drowned. The current carried them about a mile farther down the creek



to Stone Head, where they were washed ashore and buried the next day. People who were at the burial said there were as many people at that funeral as came to a person's funeral, for those horses were friends to all the people.

Can you imagine the agony there was in our home that night as people kept calling that "Doc" was still in the water? He had bought me a new doll for Christmas and I sat in my little rocking chair and rocked my doll while we waited for the calls that came until the call finally came that he had been saved. I still have that doll and, although that was 64 years ago, it is all very vivid in my memory. A good friend and neighbor, Ben Clark, loaned Father his team of horses and buggy until he could find a team to buy but they were never the same or as dear as Bess and Fred, the ones that were drowned.

Years passed, one much the same as another, and Father grew old before his time. Automobiles (Model T Fords) were taking the place of horses and, although he never owned an automobile, some-

times if there was a "hurry up" call someone would come and get him in a car.

In those days, horses were terribly frightened by the "noisy, roaring monsters," and they would shy, run away or rear up on their hind legs, and Father would have to get out and hold them by the bridle and soothe them until the car passed. I remember that happened one time when I was with him, and although it was very frightening, I did not panic but kept still and when it was all over Father said to me, "You did well. Most women would have screamed or fainted." That was one of the few times he ever complimented me.

As he grew older and could not practice as much, his favorite pastime was to sit in his hickory chair in the shade of the house and read a book on obstetrics or his little black Masonic book which he loved so much. That little black book was given to his son, Clifford, when he became a Mason and he, in turn, gave it to his son, Alfred, when he became a Mason, so it has served

three generations of Ralphys. The son and grandson both went ahead to the Murat Shrine Scottish Rite and 32nd degree of Masonry. Clifford was a charter member of Murat Shrine and received his 50-year Shrine pin a year before he died.

Dr. Ralphy passed from this life Aug. 18, 1928, at the age of 74 years, after an illness of five years. He was survived by his wife, one son, three daughters and four grandchildren.

Here I quote from the Brown County Democrat of that time which, I think, is a fitting tribute to one who had served the people of Brown County and surrounding counties for nearly 50 years. (It followed a brief sketch of his life but I don't know who wrote it.)

"But Dr. Ralphy is dead and hundreds of families throughout the county feel they have lost a faithful and tried friend, in other words a servant always ready to serve both medically and financially."

R. R. 3

Nashville, Ind. 47448



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## Drug Procurement

**T**HE drug procurement policies of the Department of Defense are outlined most adequately in an editorial entitled "Rational Drug Procurement or Caveat Emptor?" which appeared in the August 1972 issue of MILITARY MEDICINE.

Pharmaceutical supplies are bought centrally for all the armed forces. Suppliers are selected on basis of quality and the lowest bid. The editorial explains how the best quality drugs may be and are obtained under this system.

The drug standards and certification system of the Food and Drug Administration are not adequate safeguards in this instance, because the FDA standards are necessarily fairly broad and the FDA inspection system is budgeted at such a limited financial level as to be incapable of frequent thoroughgoing plant inspections.

The Department of Defense accomplishes pharmaceutical procurement for all armed services through the agency of the DOD integrated medical materiel manager, Defense Personnel Support Center (DPSC), located in Philadelphia.

This agency starts with a set of specifications which, if complied

with, will result in top quality products. In addition, any manufacturer desiring to bid on an order may be inspected and surveyed prior to the awarding of a contract, to insure the capability of producing dependable drugs.

A set of manufacturing standards has been published. The standards delineate organization structure, personnel requirements and qualifications, plant arrangement and facilities, product controls, laboratory facilities, operational standards, and plant maintenance and sanitation.

The most important facet of the survey is to determine that a company has an objective and effective quality control system. Since 1962, about 45% of all plants surveyed have failed. In addition, approximately one-half of all samples requested prior to award of contract were rejected for failure to meet standards.

The DPSC program also includes three more steps after drugs are procured—laboratory analysis, complaint evaluation and pharmacological testing.

The efficacy of the system is attested to by the fact that during fiscal years 1968, 1969 and 1970 the FDA recalled 711 drug products, 707 and 951, respectively,

while for the same periods the DPSC recalled four, three and one drug product.

The names of the companies doing business with DPSC on particular products are a matter of public record. And, except for the slight possibility that manufacturing standard of any one company may change, this record could be of assistance to other, though smaller, buyers of drugs in their search for excellence.

The editorialist points out that large companies are not necessarily good nor are small companies necessarily poor producers. The cautious and scientific testing of facilities and products provides the answer to high quality drug procurement.

## A Retail Druggist Comments on Substitution

**N**OT all pharmacists want to repeal the laws and regulations which prohibit substitution in prescription filling. Retail druggists, the pharmacists in close contact with doctors and medical care, are almost all in favor of maintaining the anti-substitution laws.

For instance, Clark's Drug Store of Greenville, Texas, which publishes a periodic letter to the doc-



tors, had this to say in their June 1972 letter:

"It is our belief that the only way to fill a prescription is exactly as you or we would want one filled for "Our Own." There is no substitute for quality.

"GENERICs can surely cover a multitude of sins! There is rarely a day goes by in which we do not receive offers to sell us 'Equivalent' or 'Same Thing As' medication that we absolutely would not take ourselves, therefore we will not stock for filling any prescription. Many of the "generic" houses go so far as to duplicate a brand name's color and marking.

"We receive many prescriptions which are written open or generically. We fill these just as we would want our own filled. A few examples of our idea of proper filling of generics are as follows:

On calls for Tetracycline, we supply Lederle Achromycin V, Squibb Sumycin or Upjohn Panmycin.

On calls for Ampicillin, it is our custom to fill with Wyeth Omnipen.

On calls for Thyroid, we supply Armour.

On calls for Digitoxin, we supply Lilly Crystodigin.

On calls for Digoxin, we of course supply Burroughs Wellcome Lanoxin.

"We think this should let you know that we think quality first, price second.

"We do not believe in substitution. You can count on us giving the exact brand and quality you prescribe, unless you leave the choice open for us to use our judgement."

## Guest Editorials

Ah, So!

THEY actually said it! The Democratic Party Platform Com-

mittee has said (see *This Month in Washington*), "Good health is the least this society should promise its citizens. . . . We endorse the principle that good health is a right of all Americans."

Americans are overweight and flabby. Consumption of cigarettes is increasing, in spite of all the warnings about the hazards of smoking. Abuse of drugs—legitimate and otherwise—is on the increase. The atmosphere and water are being made health hazards by our unwillingness to control our wastes. And worst of all, we continue to carry the most explosive of all mixtures—alcohol and gasoline—at top speeds over our highways.

We can spend all our money on health care systems, and talk until our voices fail, but good health cannot be forced on those unwilling to receive it. Until the American people are willing to discipline themselves, "Good Health for every American" is a vacant promise, useful only as political rhetoric.—**John B. Thomison, M.D., Editor, *Journal of the Tennessee Medical Ass'n.*, Aug. 1972. Reprinted with permission.**

## Federal Standards Established for Child Restraints

THE federal government has established safety standards for child restraint devices for youngsters who ride in automobiles.

All child restraint devices manufactured on or after April 1, 1971, must meet the performance requirements set by Federal Motor Vehicle Standard No. 213.

When shopping for infant carriers, carbeds, car seats or harnesses for children, look for the label which provides the date of manufacture as well as the manufacturer's name and the weight and height of

child for whom the device will give the required protection.

Many pre-standard child restraint devices were and are unsafe. Look for the date.

It is estimated that in the last 10 years over 10,000 children under the age of four years were killed in highway crashes. Most of these children died because at the moment of the crash they had no restraint to prevent them from turning into small projectiles inside the passenger car compartment.

Others died because the restraint devices in use were not strong enough or were not properly used.—**Courtesy of Indiana Traffic Safety Council**

## Editorial Notes . . .

**Senator Birch Bayh has introduced a bill to require tracer elements in schedule II and III stimulant and depressant drugs, including amphetamines and barbiturates.** The idea is to enable law enforcement agencies to identify the source of diverted controlled drugs. The bill would authorize revocation of licenses of manufacturers, wholesalers and retailers for failure to provide effective controls, or for allowing the controlled drugs to escape control.

**An epidemic of accidental deaths from asphyxiation due to indoor charcoal cookery serves to remind us that the public is not enough aware of the insidious danger.** Outdoors—nothing better, indoors—nothing worse, unless it is parking in a closed garage with the motor running. Hibachi cooking indoors usually produces enough grease fumes to make adequate ventilation necessary, but when a hibachi or other grill containing hot, flameless charcoal is brought indoors after outdoor cooking, it will generate a lethal concentration of carbon mon-



oxide. Medical societies should alert the public.

Swallowing one dry teaspoon of granulated sugar has been clinically tested for the cure of hiccoughs. It was successful nine times out of 20. Three of the cures relapsed but were cured the second time by repeat dosage. The Health Insurance Institute recommends it as the initial treatment, in preference to the multitude of household remedies.

The total number of fires in the U.S. last year was up by 7%. One of the sharpest rises occurred in hospitals, nursing homes and other institutional buildings, 18,200 fires in '71 as compared to 14,000 in 1970. Deaths from fire were slightly less, but property destruction was increased.

Safety-closure, child-resistant containers are now in effect for all aspirin-containing products. Dispensing physicians must comply as well as pharmacists. The rule applies to samples as well as regular packages. The physician may prescribe a container other than child-resistant for patients who are arthritic. The patient may request and obtain the standard packaging even without instructions from the doctor.

"Teaching About Drugs, K-12" is the most widely used drug abuse education curriculum guide extant today. It was produced by the Pharmaceutical Manufacturers Association and the American School Health Association. Now in its third edition, it is rated as excellent or good by 90% of the teachers who were questioned recently. It is designed to help teachers in the

grades from kindergarten to the 12th.

Comparison of public assistance medical care drug expenses in states with closed formularies with drug expenses in states without a drug formulary or with open or unrestricted formularies show no money-saving effect for closed formularies. Administrative and policing expenses paid by states with closed formularies more than equaled the economic savings. And, contrary to what would be expected, inventories were much larger in the case of closed formulary states.

Part of the health pact which resulted from President Nixon's visit to Russia in May is an agreement for the exchange of anti-cancer drugs. Protection of authorship rights is guaranteed. Both parties have agreed that research data will not be released without permission of the party supplying the drugs. A general exchange of all information on chemotherapy and joint meetings for discussion are a part of the plan.

A French speleologist, Michel Siffre, recently terminated a six and one-half months residence in a cave in Texas. The goal of the experiment was to study changes in the sleep-wakefulness cycle of a subject removed from any indication of hour or time. Siffre went through a brief period of sleeping and waking on a 48-hour cycle and then settled to a cycle of 26 hours, eight of which were spent sleeping.


Embryo banks are possible in the future of animal breeding and perhaps for human reproduction. An English researcher artificially fertilized mice ovums with male sperm

in a test tube. When each had reached the eight-cell stage the temperature was lowered to minus 79 Centigrade. The embryos were later thawed and implanted in foster mothers and developed into normal mice.

Dr. Austin Smith, one time editor of JAMA, and now chairman of Parke, Davis & Company, feels that government regulatory agencies may have become the most powerful "branch" of government, exceeding legislative, executive and judicial. One agency, the Occupational Safety and Health Administration, issued 15,000 orders in one year. A recent survey found it impossible to determine how many regulatory agencies now exist.



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*The Journal* welcomes the following physicians who have become members of the Indiana State Medical Association since the publication of the Roster of Members in the June issue:

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Columbus 47201

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412 North Meter St.  
Portland 47371

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1820 East Columbus Drive  
East Chicago 46312

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Beatty Memorial Hosp., P.O. Box 5  
Westville 46391

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6214 Broadway  
Indianapolis 46220

Robert E. Cravens, M.D.  
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Indianapolis 46224

William H. Dick, M.D.  
Methodist Hospital  
Indianapolis 46202

Major James V. Faris, M.D.  
U. S. Army Hospital  
Fort Carson, CO 80913

D. Preston Figge, M.D.  
2920 Colerain Dr.  
Indianapolis 46222

Theodore F. Hegeman, M.D.  
1254 Darby Lane  
Indianapolis 46260

D. Duane Houser, M.D.  
1815 N. Capitol Ave. #302  
Indianapolis 46202

Donald Herbert Lauer, M.D.  
100 North Madison  
Greenwood 46142

Neale A. Moosey, M.D.  
1303 N. Arlington  
Indianapolis 46219

Antonio Recio Recinto, M.D.  
Marion County Child Guidance  
Center  
1100 West Michigan St.  
Indianapolis 46202

John Lance Rubush, M.D.  
1815 North Capitol  
Indianapolis 46202

Paul E. Schmidt, M.D.  
3266 N. Meridian St.  
Indianapolis 46208

Daniel H. Spitzberg, M.D.  
10455 North College Ave.  
Indianapolis 46280

Carlos A. Silva, M.D.  
1815 N. Capitol Ave. #G7  
Indianapolis 46202

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c/o Porter Memorial Hosp.  
Valparaiso 46383

Constance Covington, M.D.  
1101 East Glendale  
Valparaiso 46383

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Batesville 47006

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South Bend 46622

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\* \* \* \* \*

CHAMPUS benefits under the Basic Program are not available when the required services constitute domiciliary or custodial care. Domiciliary or custodial care is defined as that type of care designed essentially to assist the individual in meeting his activities of daily living. These include services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, preparation of special diets, and supervision over medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel.

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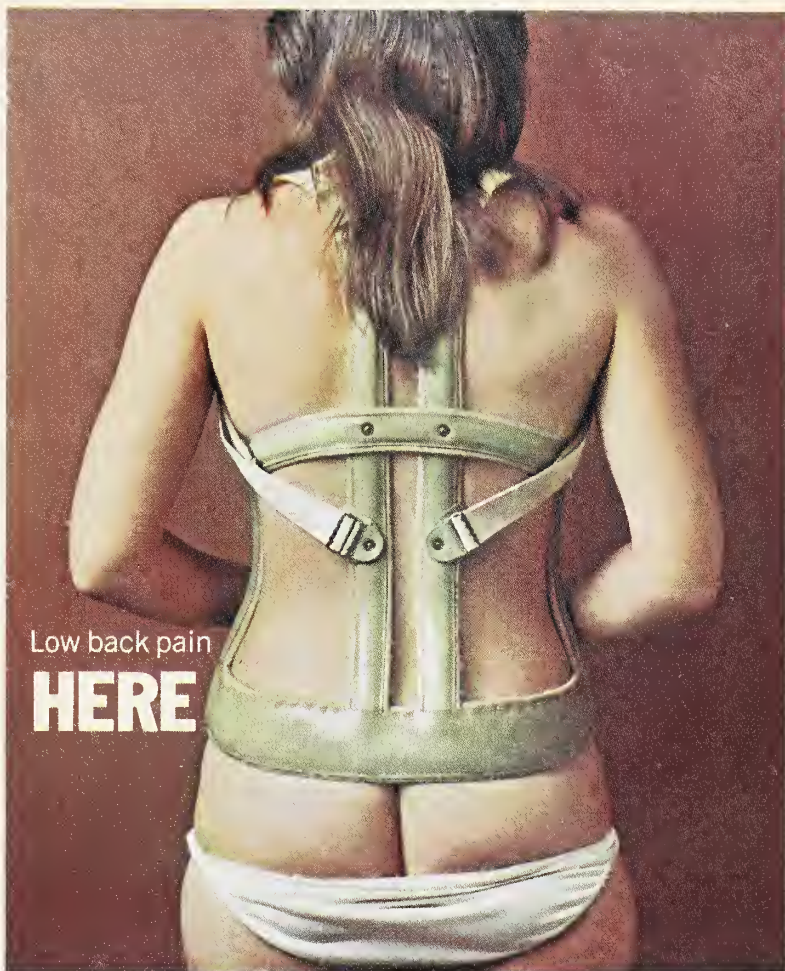


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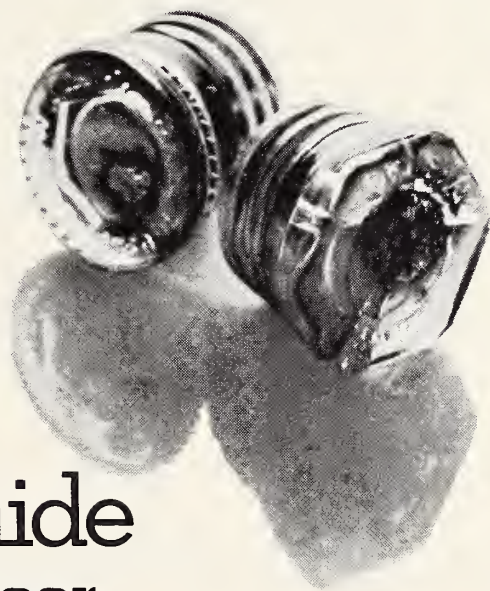






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with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

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When the government decides what drug should be prescribed, is the patient better served?

# Relative Efficacy

In the fall of 1971, several officials of the Food and Drug Administration began stating that drug manufacturers should provide information on the comparative usefulness of their medications in the treatment of specific conditions. Such "relative efficacy" data they said should be made part of the prescribing information supplied to physicians in drug product labeling.

To persons familiar with the history of the Food, Drug, and Cosmetic Act, the statements from FDA were far from novel. Indeed, the matter had been thoroughly discussed a decade before, when Congress was in the process of enacting the 1962 Amendments to the Act.

At that time, Secretary of Health, Education, and Welfare, Abraham Ribicoff, stated unequivocally that those who had expressed concern that the new law might be used to permit the Federal Government to make relative efficacy judgments had "no basis for such apprehensions." The proposed amendments, he stressed, "would merely require a showing that the new drug described in the application is safe for use and is effective in use, under conditions prescribed, recommended or suggested, in the labeling thereof. This would not require a showing of relatively greater efficacy than that of other drugs. It would merely require that a drug claimed to be effective for a particular purpose had been demonstrated by sound scientific procedures to be effective for that purpose. In short, it must live up to the claims made for it."<sup>1</sup>

## "We Do Not Want It"

When asked specifically if FDA wanted the power to decide relative efficacy, Secretary Ribicoff answered, "We do not seek it. We do not want it. And my testimony in-

dicated we do not intend to pass on it. . . . We do not want to pass on relative efficacy. We do not want to say that drug A is better than drug B or B is greater than C. We are not looking for that at all, and we do not think it is necessary."

Colorado Senator John A. Carroll pursued the matter still further, noting: "you know, some of the doctors have testified that they themselves do not know that drugs operate differently on different people." Mr. Ribicoff agreed, "Absolutely correct. . . . We would not and do not intend and do not want to pass on relative efficacy. This is no power we seek and no power we desire."<sup>2</sup>

It would be difficult to express a more clearcut denial of any intention to act to determine relative efficacy than that of the former HEW Secretary.

## Change Appears Intended

Yet it appears that a change in the Department's stated position is intended by some at FDA, apparently on the unsupportable grounds that drug labeling, which does not indicate the product's relative position on a therapeutic scale, is not fully informative, or is somehow false or misleading.

In order to follow that reasoning, one must assume that a prescribing priority system can be clearly established, and, if so, that the Federal Government should be the judging agency.

And that is the crux of the matter.

The question of whether relative efficacy *should* be judged by the government is preceded by the question of whether it *can* be accurately determined. For some drugs, a consensus of expert opinion has been reached. In these cases, the less desirable drug has either vanished

(bromides for anxiety, mercurials for diuresis), or has shrunk to prescribing levels justified by the advantages it retains (veratrum for hypertension, sulfonamides for infection). Results of this sort do not require government intervention. On the contrary, it may well be that attempts to impose consensus by fiat rather than by scientific and professional interaction would have had a counterproductive effect.

That leaves many areas of therapy and many groups of drugs for which a consensus has not been reached. Can the government line up, for example, all of the drugs in use against high blood pressure, and meaningfully arrange them in order of efficacy? If so, the physician's task could be simplified immensely.

But the answer to this question is *no*.

A number of controlled studies have failed to show any significant difference in efficacy between the major antihypertensive drugs.<sup>3</sup> Yet, while the experts in the field and the prescribing physicians may be at odds not one seems to claim that the major antihypertensive drugs now available are indistinguishable with respect to efficacy or usefulness.

## Legislation Pending

While informed experts decline to make arbitrary judgments about the order in which particular drug products should be used, legislation is now pending (S. 2812, 92nd Congress) that would prevent the marketing of any drug not proven to be better than those already available. Had this bill been in effect when the first thiazide diuretics reached the market, it seems likely that only a handful would be available. Researchers, encouraged to proceed even if their discoveries were only modest, found more than



a dozen such products, offering the physician a broad range of activity to meet his patient's needs. And, the availability of these alternatives has doubtless been a factor in the reduction—by about 15% at wholesale—in the price of the average diuretic.

It is thus impossible to justify the relative efficacy requirement from an economic point of view, let alone a medical one.

### **Some Say Diuretic Market Saturated**

Still, some FDA employees are ready to decide such issues. According to the *Washington Post* of Oct. 24, 1971, "some [FDA] scientists say that the diuretic market is saturated. 'We need another diuretic like a hole in the head' one FDA scientist said."

The question asks itself: Do the American people want FDA deciding when the last diuretic has been discovered, or instead do they wish to see further research leading to improved diuretics encouraged?

In this connection, it is noteworthy that early tests of a drug often fail to uncover some of its best advantages. For example:

- The early research on dimenhydrinate was directed toward its antihistaminic properties; only late in the program was another of its characteristics—its usefulness against motion sickness—noticed;

- The first research using the phenothiazines was in sedation; the drugs' cardinal value in psychoses came to clinicians' attention later;

- Again, the value of isoproterenol in shock, of mafenide acetate in burns, and of lidocaine in cardiac arrhythmia, were not recognized for years after their widespread use for other, less important medical indications.

Had FDA taken the shortsighted position then that one or two good drugs for each therapeutic need should suffice, the drugs just mentioned might never have been marketed; FDA could have said, in each case, that still another antihistamine, another sedative, one more cardiac stimulant, yet another topical antibacterial, and another local anesthetic—was not needed.

Because FDA did not make such arguments when these drugs were before them for approval, hundreds of thousands of patients have benefited enormously, in many cases to

the extent of recovering the chance to live.

Similarly, there is a difference of medical opinion on the value of antihistamines, corticosteroids and sympathomimetic agents against allergy, with no clearcut consensus on the issue. A lack of unanimity also exists with respect to the therapy of peptic ulcer, where anticholinergics and antacids are used, and in various musculoskeletal conditions, where some advocate muscle relaxants and others order only phenobarbital, much depends on the particular patient.

### **Relative Merits Found Through Experience**

In such cases, FDA traditionally has followed the lawfully required and prudent course of letting the relative merits of the drug be found through experience, once the general questions of safety and efficacy have been answered. The National Academy of Sciences/National Research Council's 1969 Drug Efficacy Study commented on the point:

"The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."

That process has been responsible for the large array of steroids of value in contraception, for example, and for the development of new drugs for the management of gout and diabetes. In each of these areas, seemingly trivial differences in the drug not infrequently make major differences to patients—and make arbitrary relative efficacy judgments impossible.

Even in the case of the antibiotics, where it is often assumed that it is easy to match the medication against the disease, it is not uncommon to find authoritative disagreements as to the drugs of first choice (or second and third for that matter). For example, one well-known medical guide<sup>4</sup> suggests that the drug of first choice in the treatment of acute gonococcal infections is procaine penicillin G, and that a tetracycline or erythromycin may be used as alternatives; a second and equally respected book<sup>5</sup> men-

tions no alternatives; a third<sup>6</sup> lists erythromycin ahead of tetracycline, and adds a cephalosporin to the list for the physician to consider; still another book<sup>7</sup> does not list any of the alternates listed in <sup>4</sup> and <sup>6</sup>, but adds six separate penicillinase-resistant penicillins, and (any) sulfonamide. None of the referenced guides mentions spectinomycin, a relatively new (1971) antibiotic that has been the subject of numerous favorable reports.

Clearly, there is no unanimity as to the precise ranking of the alternates to penicillin G in treating gonococcal infections; indeed, there is no agreement as to what the alternatives are.

It must be borne in mind that the physician is not only dealing with a disease, which may follow a varied course, but also with an individual patient, whose reactions to the drugs prescribed may be crucial to the outcome of the therapy. Because the individual patient's reactions can make it dangerous to give him what for most patients is the "drug of choice," the physician must be permitted freedom to use his own judgment.

### **Clinical Knowledge . . . May Be the Best**

Recognizing the importance of allowing the doctors' judgment to prevail, Cornell University's Peter Dineen, M.D., in his chapter on antibacterial drugs in the 1970-71 *Drugs of Choice* wrote:

"Clinical knowledge is often the method used in selecting a drug, and it may be the best. Properly applied it combines a knowledge of experimental and clinical evidence of the efficacy of various drugs with personal clinical experience. Once the infecting organism is identified, therefore, a reasonable selection of drugs can be made based on experience and knowledge."

Louis Weinstein, Ph.D., M.D., of Tufts, in his chapter on the chemotherapy of microbial diseases in the Goodman and Gilman text, put it another way:

"Presentation of choices of specific agents for the treatment of various infections is always provocative of discussion and disagreement because



such choices often represent the distillate of personal experiences that may not duplicate those of others. . . . To complicate matters, sensitivity patterns of a number of micro-organisms often vary with the hospital or clinic in which they are isolated. . . . The material presented in this table represents the practice of the author based on his experience with the management of these infections. It is not intended to suggest that the indicated choices are necessarily those of other physicians or that the order is absolute. . . ."

And, Dr. Louis Lasagna, head of the University of Rochester Medical School's department of pharmacology and toxicology, has observed:

"Progress could be defined as discovering truths that are unrecognized or unaccepted by the experts. As someone who has been dubbed an expert by others, and who rather enjoys the privileges that go with that label, I am not suggesting that expertise has no utility in the world. But the experts can err—witness the thromboembolic hazards of the Pill, or the clinical reports (so long derided) on the antidepressant properties of phenothiazines, or the growing body of knowledge that USP standards (concocted by experts) are inadequate. (And, what is more, the experts often disagree among themselves—if you doubt this, poll any group of experts on the antibiotics of choice to be used in treating septicemia of unknown origin.)" (*Clinical Pharmacology and Therapeutics* 11:3, p. 443).

### Need for Flexibility

If there is a difference of expert opinion and a need for flexibility in the selection of antibiotics, that need is doubly evident in the selection of many other modes of therapy, where the causative agent or factors may well be less clearly understood, and the characteristics that distinguish one useful drug from another may be considerably less discreet. In the treatment of psychotic dis-

orders, for example, it is widely acknowledged that the relative value of one major tranquilizer as against the others cannot be determined in advance, even though these agents have been under careful and aggressive study for more than 20 years.

Again, the choice of digitalis preparations still presents a challenge, although physicians have studied the use of various forms of these cardiac drugs for about three millennia. Still, according to digitalis authorities Gordon K. Moe, Ph.D., M.D., and Alfred E. Farah, M.D. in Goodman & Gilman (p. 700): "What really matters is not so much the choice or purity of preparations, but the wisdom with which the drug is used by the physician."

Recent research in pharmacology indicates that there may well be a sound scientific foundation for recognizing the full importance of the use of skillful case-by-case judgment that cannot be performed by experts or authorities absent from the patient-doctor transaction.

### Four Main Factors

The four main factors in a therapeutic relationship are: (1) Physician prescribes (2) drug against (3) disease of (4) the patient. The notion of relative efficacy assumes that for a given disease (factor 3), drugs can be ranked independent of physician (factor 1) and patient (factor 4). This assumption is false. Recent discoveries suggest that the individuality of the patient, and of the physician, play very important roles in determining the effectiveness of drug treatment.

In one review<sup>8</sup> we read:

"Although it has been recognized for many years that patient-environmental variation is important in determining drug effects, only recently has it been appreciated that genetic factors may play a large part in subtle drug-patient variation. Not all drug-patient variations can be ascribed to genetic factors, but the increasing use of metabolic blocking drugs and enzyme inducing drugs has heightened the clinical awareness of possible subtle pharmacogenic problems."

In the area of mental illness, at least, there are increasing suggestions that the importance and effec-

tiveness of drug therapy vary markedly depending, in part, upon the therapist's experience, values, and personality.<sup>9</sup>

### Difficult to Assess

Dr. Louis Lasagna discussed the value of relative efficacy information during a January 1972 conference at the University of Rochester. "To be against information on relative efficacy," he said, "is to be against apple pie, mother love, and the American flag. It turns out, however, that relative efficacy is very difficult to assess. . . . How nice it would be to have controlled trials data on all those drugs in patients who have for example, angina, coronary heart failure, hypertension, melancholia and asthma—but the mind boggles as you think about doing these trials."

Supposing, for example, that a new antithyroid drug were marketed, Dr. Lasagna posited that "You might say, 'Well, shouldn't the doctor know how this drug fits in, in terms of relative efficacy, relative toxicity, with other drugs, radioactivity, surgery—a few of the major modalities available for treating hyperthyroidism?' It would be nice again indeed; but again, the prospects of coming up with controlled trials comparing all of those simultaneously is pretty remote."

Moreover, there is a real question as to whether the cost of designing meaningful, definitive studies would be even remotely justified by the patient benefits to be expected. In most therapeutic classes, the number of distinct drug entities of value in treating a particular condition is small, frequently less than a dozen. Broadly speaking, the pharmacological effects of the group can usually be described, as is done in any of the standard texts of therapeutics. Using this information, and adding his own background and experience, the physician chooses one compound, basing his choice on the particular therapeutic (or economic) qualities it offers his patient.

Rather than expend limited clinical research resources testing one well-known drug against another, the prudent use of those resources clearly lies in the development of entirely new compounds.

Meanwhile, information on the relative place of marketed drugs,



weighing their therapeutic indexes against alternate therapy, is being collected and published in the usual ways. Better data on the overall ratio of desired effects to unwanted ones, which characterizes a given group of compounds when used in a particular situation, assists the physician, not merely in choosing a given drug, but also in selecting from alternative classes of compounds of possible value to the patient.

The provision, by their peers, of information for physicians' guidance is, of course, a far different thing than the provision of even the same information by the federal government, whose "guidelines" more often than not carry the force of law. The question naturally arises: What does it mean when the government—as distinguished from a private body or expert—asserts that Drug A is the one of first choice in Condition A? What is the physician's legal position if, on the basis of his personal experience and educational background, he responsibly disagrees?

The question has been raised many times, and in various ways. Over the years FDA officials have challenged distinguished clinicians and practicing doctors who openly advocate usage of prescription drugs in conditions and at dosage levels not indicated in the FDA-approved labeling.

### Calls Attention to Danger

In 1967, for example, Dr. Walter Modell reported that FDA lawyers were claiming that "publishers, authors and editors who have written, approved and published drug dosages which deviate from those recommended by the FDA are liable for damages. . . ." Objecting to this as regulation of medicine by fiat, "to which all doctors will have to turn like Holy Writ when they seek help on drugs," Dr. Modell called attention to the danger of letting FDA assume such power. "There must be free and unrestricted expression of opinion and publication of experience with drugs already officially described and delimited in FDA stuffers," he said, "if progress is to be made in therapeutics and if egregious errors, one way or the other, by the FDA, are to be promptly published and rectified."

Moreover, he said, "in the case of

every single drug, the determination of actual efficacy, proper dosage, and safe use requires substantial experience by the expert as well as by the general practitioner. It is held by many that it takes about five years before a definitive statement can be made about a new drug."

The issue was rejoined in 1970, when FDA Bureau of Drugs Director Henry Simmons, M.D., advised doctors that whenever they intended to prescribe a medication for use in a manner not approved in the official FDA labeling, they should first file a "Notice of Claimed Investigational Exemption for a New Drug" form.

### AMA Objects Vigorously

AMA's Department of Drugs objected vigorously, fearing that "the FDA proposes to approve, forbid, monitor, collect, collate, evaluate, and disseminate results of all clinical experience with drugs in this country that is not consistent with package insert recommendations, regardless of the agency's statutory jurisdiction. . . . We believe the FDA should devote full attention to meeting its statutory obligations, not attempt to expand its statutory grant by regulating the practice of medicine."

AMA stressed that "the physician should always remember a subtle but important distinction: The FDA has no legal authority to approve the uses of marketed drugs; it approves what a manufacturer may say about these uses in its labeling and advertising."<sup>10</sup> Earlier, AMA had published its belief that "the package insert is part of the labeling of a drug and not a legal restriction on the thoughtful and careful use of a drug by an informed physician."<sup>11</sup>

That "subtle but important distinction" has never been acknowledged by the FDA, however, and increasingly, in liability actions brought against physicians, failure to adhere to the labeling recommendations is being portrayed by medical malpractice lawyers as *ipso facto* evidence of wrongdoing. Recognizing this, the American Academy of Family Physicians, in an April 7, 1972 letter to FDA, said that relative efficacy judgments in government-approved labeling would carry the threat of "implied police power,

if in no other way by the threat of such regulations being used as a 'club' in malpractice suits." The Academy, which represents 31,000 family physicians, urged that FDA abandon any plans to require relative efficacy statements.

One of the most astute students of the regulatory process in drugs worldwide is Sir Derrick Dunlop, the recently retired head of Britain's Medicines Commission, a sister agency to the FDA. Speaking at a symposium in Geneva in September 1971, Sir Derrick summed up the limits of regulatory power in the area of efficacy rulings by official regulators thus:

"I do not believe that opinion on matters of efficacy should be formed by bureaucratic bodies, but rather through the free process of scientific publication, debate and undergraduate and postgraduate education. There is a danger that as regulatory agencies arrogate to themselves more and more the duty of dogmatizing on the efficacy of medicines, that a so-called learned medical profession will eventually be reduced to signing forms entitling their patients to obtain such medicines as the regulatory agencies say they may have."

In a parallel vein, the Pharmaceutical Manufacturers Association wrote to the Commissioner of FDA on December 23, 1971, asking for a statement of intention from the agency on relative efficacy. "No authority exists in the stated terms of the statutes authorizing these activities by FDA," PMA President C. Joseph Stetler wrote, "nor is there any implied authority which might be derived from the legislative history of the Act."

### PMA Asks for Clarification

Since pursuance of the plan to require relative efficacy statements "would significantly distort the practice of medicine," Stetler asked for an early clarification of FDA's position.

Four months later, in an address to the PMA's Annual Meeting, FDA Commissioner Edwards told PMA that "the physician—and he alone—can judge" the choice of medication, and that "FDA does not intend, through labeling, to preempt



his judgment." But then he added that "if all drugs are properly labeled, relative efficacy ceases to be an issue."

The question, of course, is what is proper labeling?

It is the general rule for FDA to interpret its regulatory powers very broadly; it may therefore be assumed that some agency personnel might deem it necessary for a "properly labeled" drug product to include relative efficacy information. It is imperative that the professions, the pharmaceutical industry and the public be alerted to the dangers of any official action or unannounced application of such a position by the Food and Drug Administration. There must be general recognition that labeling requirements by FDA in the area of relative effectiveness, to the extent that they are given medical and juridical recognition, would represent a fundamental new departure for American medicine, under Federal control, unlike that found in any other national system. In the end, much will depend on how effectively physicians and consumers express their desire to avoid bureaucratic control of this sort, and how well they demonstrate that such procedures do not serve the public interest. — **News Release prepared by the Pharmaceutical Manufacturer's Ass'n, June 1972.**

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#### Comments Invited

Physicians are invited to submit their comments or examples of how the government policy discussed in this article could affect their practice.

Address your comments or examples to Mr. C. Joseph Stetler, President, Pharmaceutical Manufacturers Association, 1155 Fifteenth St. N.W., Washington, D.C. 20005.



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# *CME in Indiana—A Look Before You Leap*

STEVEN D. BERKSHIRE\*  
Indianapolis

THE technical and social advances of the 1970s have made continuing medical education (CME) more important than ever. Continuing education of the physician is not new, however. Physicians have been attending scientific meetings, rounds and conferences and reading journals for decades. What is new, is the importance being placed on continuing medical education around the nation, either by the public or the medical community itself.

Indiana has been a national leader and pacesetter for developing and implementing continuing education programs. Through the "Statewide System for Medical Education" community after community has been able to become active in providing continuing education for its physicians.

During 1971-72 19 hospitals in the State provided approved intern-residency programs. Fifteen hospitals were involved with the Indiana University School of Medicine in sponsoring Visiting Professorship programs. Twenty-one hospitals participated in the WAT-21 closed circuit medical education television network and 53 were connected to the videotape network—both operated by the Medical Education Resource Program (MERP) of the I.U. School of Medicine. One hundred and fifty communities were connected to the I.U. School of

Medicine Library through the "Indiana Biomedical Information Program."

To add to this impressive list there are several short courses and conferences co-sponsored or sponsored by hospitals in Indiana, specialty societies, volunteer health agencies, and the Indiana State Medical Association. Hospitals also continue to conduct rounds, staff conferences, lecture programs and clinics for their staff physicians. It is impossible to tell how many physicians or manhours were spent in the hundreds of CME activities conducted during 1971-72.

One measurement of success of continuing medical education efforts in Indiana is what the Indiana University School of Medicine is doing as the "hub" for the "Statewide System."

During 1971-72 the School of Medicine had over 300 of its 360 faculty members participate as instructors or presenters for CME.

The Division of Postgraduate Medical Education conducted 30 formal courses in many subspecialties as well as in general medicine. Of the 1,096 physicians who attended these courses, 191 physicians repeated more than one course.

The faculty of the I.U. School of Medicine conducted 91 Visiting Professorships in the 15 hospitals participating for a total of 273 hours of instruction.

Eleven Clinical Departments jointly published a listing of staff and departmental rounds, clinics, conferences and lectures open to the practicing physician in the communities of Indiana.

During 1971-72 the Medical Education Resource Program (MERP) aired 1,623 hours of programs on the WAT-21 Network, producing many of the programs themselves.

Several physicians also took advantage of the traineeships and clinical experiences offered at the Medical Center campus. Each physician was individually matched with his own selected program and faculty.

The School of Medicine was involved in co-sponsoring, in planning and assisting in community-based courses (e.g., the Cancer Symposium in South Bend, the Oncology Seminar at Community Hospital of Indianapolis, and the "Practical Methods of Diagnosing Psychiatric Problems" seminar in Vincennes). Other co-sponsored events were planned in conjunction with the American College of Physicians, the American College of Cardiology, the American Cancer Society, the State Board of Health, the American Academy of Family Physicians, and ISMA.

Special projects included the Student - faculty - physician retreat held in January. Twenty-four students attended along with 19 faculty and 16 Indiana physicians.

Continuing Medical Education has jumped ahead by leaps and bounds in Indiana over the past few years. In order to monitor and check on the quality of the growth, continuous evaluation must take place and serious discussions on meeting the demands must be conducted.

One major effort in this area was the Assessment and Evaluation Sur-

\*Mr. Berkshire is the Program Coordinator for the Division of Postgraduate Medical Education, Indiana University School of Medicine, Indianapolis.



vey completed on the WAT-21 closed circuit medical education television and video-tape networks. The Survey was conducted by Dr. Charles Brown (Assistant Dean for Sponsored Programs at IUPUI) for the Division of Postgraduate Medical Education and the Medical Education Resource Program at the I.U. School of Medicine. The purpose of the study was to provide an assessment of the educational utility and acceptance of video-tape recordings and closed circuit television as methods of continuing medical education. Also involved in the survey was an attempt to determine the physician's perception of the helpfulness of various methods of continuing education.

Indiana physicians also have available numerous medical and scientific journals and national meetings with which to keep abreast of new developments in medicine and surgery. Indiana is becoming a center for many regional and national meetings. In 1974 the American College of Physicians will conduct another national course, as will the North Central Dialysis and Transplant Society. In 1972 and 1973 the American College of Cardiology will also be coming to Indiana for courses and the school will conduct national courses in ENT and Radiology.

1972-73 promises to be an even bigger and better year for Continuing Medical Education in Indiana.

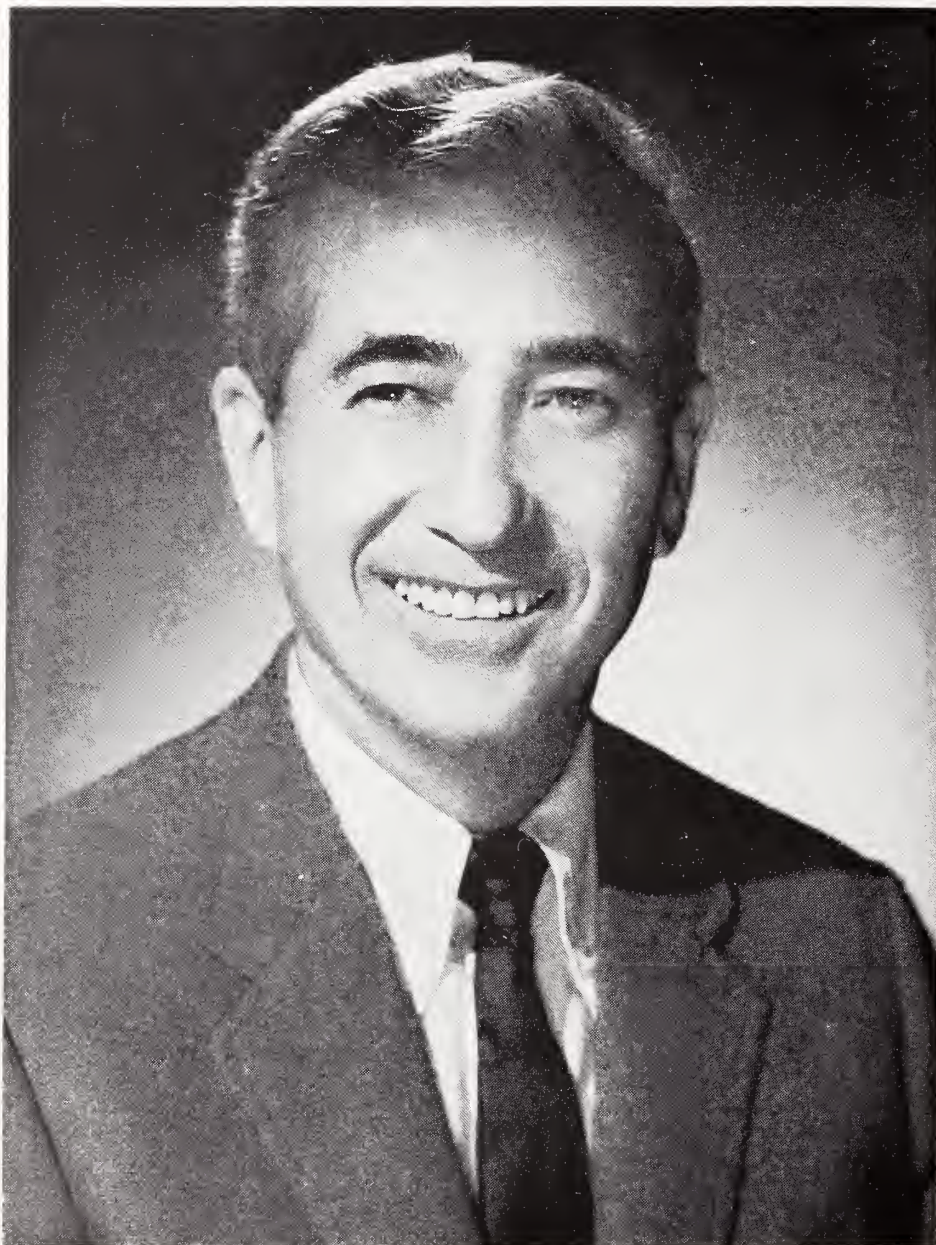
Some new activities will include a series of one hour live programs on "Current Topics in Medicine and Health Sciences" on the WAT-21 Network; clinical traineeships for physicians who have been out of practice; and symposia and seminars on vital issues concerning the medical profession. Several more hospitals and societies will be conducting short courses and conferences to meet the need and demand in the various areas of Indiana. And, of course, hospitals, societies and the School of Medicine will continue providing improved CME activities—both traditional and unique to Indiana's medical education history.

## INDIANA STATE BOARD OF HEALTH

### MONTHLY REPORT — September 1972

Disease	Sept. 1972	Aug. 1972	July 1972	Sept. 1971	Sept. 1970
Animal Bites	1400	1263	1345	1236	845
Chickenpox	51	57	123	20	26
Conjunctivitis	207	176	205	146	127
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	34	18	22	42	37
Gonorrhea	1289	907	866	910	754
Impetigo	316	174	182	235	243
Infectious Hepatitis	72	39	51	60	41
Infectious Mononucleosis	211	40	44	85	61
Influenza	2840	1138	688	584	543
Measles					
Rubeola	13	16	37	18	5
Rubella	33	33	44	72	57
Meningococcic Meningitis	0	0	0	1	0
Meningitis, Other	2	1	0	4	7
Mumps	32	35	50	37	63
Pertussis (Whooping Cough)	32	60	10	6	15
Pneumonia	352	205	213	209	198
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	870	672	708	639	512
Syphilis					
Primary & Secondary	22	48	17	28	21
All Other Syphilis	89	83	93	120	103
Tinea Capitis	8	6	2	4	5
Tuberculosis (Active)	86	53	35	74	65





JAMES H. GOSMAN, M.D.  
President  
Indiana State Medical Association  
1972-73



Dr. James H. Gosman was installed as president of the Indiana State Medical Association during the Annual Meeting in October.

Dr. Gosman's entire professional career has been dedicated to affairs and work of professional medical organizations, to the interests of voluntary medical associations and to military medicine.

He is a native Hoosier. He was born in Jasper and attended grade schools and high school there. He was awarded the B.S. degree at Indiana University in 1936 and the M.D. degree in 1938. He is presently Associate Professor of Medicine (Dermatology) at Indiana University.

He enjoyed a highly successful athletic career in basketball and baseball, both in Jasper High School and in Indiana University.

Dr. Gosman served a two-year internship at the Marion County General Hospital in Indianapolis, and was resident in surgery in the same institution in 1940-41.

His military service occupied five years during World War II. He was Flight Surgeon, U.S. Air Force, with combat duty in North Africa, Italy and Germany. He was decorated with the Legion of Merit.

After the war, Dr. Gosman spent three years in postgraduate training in dermatology at the University of Pennsylvania and, since 1949, has practiced his specialty in Indianapolis.

In addition to his appointment at Indiana University School of Medicine, he is a member of the medical staffs of many Indianapolis hospitals, and is consultant to the Veterans Administration and to Central Hospital.

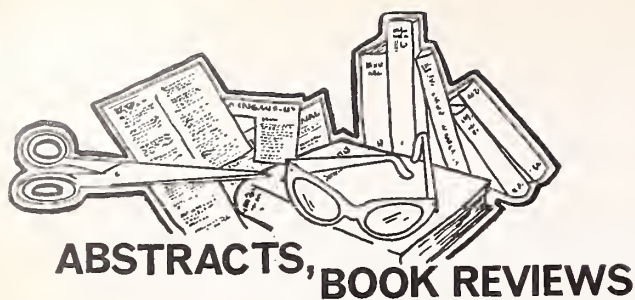
Dr. Gosman is a Fellow of the American Academy of Dermatology and a member of the Society of Investigative Dermatology of America and the Indiana Society of Dermatologists.

He has served as alternate delegate to the American Medical Association. He is past-chairman of the board of the Marion County Medical Society and has also served as its president.

Dr. Gosman is a director of the American Cancer Society, is president-elect of the Indiana Division of the American Cancer Society, and chairman of its Executive Committee.

His special interests include Comprehensive Health Planning, the American Legion, the Indianapolis Chamber of Commerce, The Hoosier 100, the Salvation Army, and the Citizens Committee for the Elimination of Tuberculosis. ◀





## HAZARDOUS TO YOUR HEALTH: A New Look at the "Health Care Crisis" in America

Marvin H. Edwards, Arlington House, New Rochelle, N.Y., 1972; 318 pages, \$9.95.

So much is being written and broadcast through the media to the general effect that the time has come when the government should take over the practice of medicine in all its regards, that it is refreshing and heartening to find a book written by a competent and well informed authority such as Marvin Edwards, which unequivocally states that the proposals for governmental control of medical care are *Hazardous to Your Health*. Dr. Marvin Edwards is not a physician but a doctor of laws, an editor, and a public relations expert with a wide experience in newspaper work, advertising and public relations. Since 1968, he has been editor of *Private Practice*, a national magazine with a circulation of 150,000 that reports specifically on the political and socioeconomic factors affecting medical practice in the United States. The author points out that, since he is not a physician, he is therefore not concerned with the increase or decrease in doctors' income which might result from government medical programs. In fact, he writes "this is *NOT* a pro-doctor book. This is, instead, a *pro-patient* book. For if national health insurance or any other broad scale government health programs which are being proposed become law, it is the patient who will pay, in terms of higher medical costs (through increased taxation), and lower quality medical care."

The book contains a most sensitive and inspiring preface which lays the groundwork for a detailed examination of the catastrophes that face the people of the United States if the present programs which are being proposed for nationalization of health care are enacted into law.

The first part of the book deals with the campaign which has been waged for several decades to bring about a complete takeover of American health care, and to replace what is left of our free enterprise system of medical care by an assortment of socialistic federal programs. The second section deals with the present so-called "crisis" and analyzes the policies which are being forced on the American people by a wide assortment of left-wing, socialistic, and liberal elements of the nation. The third part contains an analysis of the many facets of the problems of medical care which are being presented to the people in a variety of frequently horribly distorted statements. The fourth part discusses the various choices which have been presented, which are being presented, and which face the American people.

The book concludes with a short and useful statement of the "history of the campaign for national health insurance," together with a second Appendix which outlines the "planners' plans." Finally, there is an excellent index, which is an invaluable part of the book for those who will be using this excellent and useful volume for reference purposes.

This book should be read by every American physician; but,

even more so, it should be drawn to the attention of every American citizen who values his freedom, and who values the high quality of American medical care, as it is now practiced. The catastrophe of the replacement of American medicine as it has been practiced in the past by a Federal government system which is so persuasively and deceptively called "health insurance." The great shame is that it is difficult to imagine how a book of this kind can reach the notice of enough of the people soon enough to stem the socialistic tide. So, it is the duty of every physician to draw the facts in this book to the attention of their patients at the earliest possible opportunity. Copies of this book should be in every waiting room, and medical societies should invest in copies to be placed in public libraries, school libraries, and reference rooms wherever possible.

LALL G. MONTGOMERY, M.D.  
Muncie

## BLOOD AND OTHER BODY FLUIDS

Biological Handbook issued under the auspices of Federation of American Societies for Experimental Biology (FASEB)—edited by Philip L. Altman and Dorothy S. Dittmer, Third Edition, 1971; 540 pages with innumerable tables, one color plate, countless references and an excellent index.

It is almost presumptuous for a mere M.D. to think that he can *really* give a professional appraisal of this vast conglomerate of data—sheer facts—involving not only Man and other mammals but also birds, fishes, reptiles, amphibians and practically all representative living creatures.

I did spot check much basic, human physiology. The plate on page 141 giving the normal blood and marrow cells of man is beautifully reproduced in very high perfect coloring. The minutely detailed blood oxygen dissociation curves cannot be faulted; compactly and concisely, the whole story is there for all to see. The effects of altitude on the organism are told with similar precision.

I must compliment the editors who had to assemble the lifetime efforts of the several hundred contributors and then proceed to make a coherent whole of the same! Surely that took a *lot* of the proverbial "blood, sweat and tears." The printing, binding and paper are of the highest quality. This volume is a must for the libraries of medical schools, hospitals, colleges and similar institutions.

ARNOLD LIEBERMAN, M.D.  
New York City

## MALNUTRITION, ITS CAUSATION AND CONTROL

Robson, J.R.K., Vols. I and II, Gordon and Breach, New York, 1972.

*Malnutrition, its Causation and Control*, is a two-volume work authored by John R. K. Robson, M.D., of the School of Public Health, University of Michigan, in collaboration with Frances A. Larkin, Ph.D., Anita M. Sandretto, M.P.H., both of whom are from the School of Public Health, University of Michigan, and Bahram Tadayyon, Ph.D., of the Mashad University, Mashad, Iran. The authors have had a wide range of experience that qualifies them to write on this subject. The book approaches malnutrition as an ecological problem. The authors relate malnutrition to physiology, pathology, human behavior, and other factors constituting the ecology of food and nutrition. They consider and provide answers in depth to several questions, including:



- What are the manifestations of malnutrition?
- What are the causes?
- What is normal nutrition?
- What are nutritional requirements, and how well have they been met?
- What can be done to promote better nutrition?
- How can we change human behavior and organization to insure better nutrition?

The book approaches these difficult questions in a highly competent manner. Readability is considerably increased by inclusion of a goodly number of well done flow charts, diagrams, and photographs. The average physician in the United States will not find great use for these excellent volumes in his practice. They are recommended for persons in public health and for serious students of nutrition, be they in medicine, nursing, health, or related sciences.

W. D. SNIVELY, JR., M.D.  
Evansville

## GENERAL UROLOGY

Donald R. Smith, M.D., Lange Medical Publications, Los Altos, Calif., Seventh Edition, 1972; 436 pages, \$8.50.

When a textbook such as *General Urology* is published from 1959 to 1972, through seven editions, it must have some qualities that the buyer finds desirable. Of course the price, at \$8.50, is not outrageous (as some of the medical textbook prices are today) and that alone is an incentive to have this book. But it is an admirable summary of the art and science of urology and the soft cover format detracts not at all from the contents.

These are divided into 31 chapters and they cover the gamut of topics. Let me name just three which appealed to me especially. These are, Radioisotopic Kidney Studies (Chapter 8), Vesicoureteral Reflux (Chapter 11) and Disorders of the Kidneys (Chapter 21). The information in all sections, however, is clearly presented and in sufficient depth to be of value to the urologist either early or late in his training. I like, when reading a general text such as this, to correlate my private experience with the authors and think, "Of course, I saw a child with duplicated ureters causing reflux," and so on. When we think we have no need for this type of review, we might be in trouble intellectually.

There are many practical "nuggets" of urological art which Dr. Smith includes here and his information seems to be surprisingly up to date. In other words, this is truly a new edition and has been modernized and not merely rehashed in a new cover.

In this day of ongoing peer review and re-examination it will behoove us to use textbooks such as this to refresh in our minds sometimes forgotten basic tenets of knowledge. General practitioners, urology or surgical residents, and practicing urologists will all gain useful information from this book. I commend the Lange Publications for another success.

RODNEY A. MANNION, M.D.  
LaPorte

## A NATIONAL SYMPOSIUM ON CHILD ABUSE

Members of a Symposium, October 1971, The American Humane Association, Children's Division, Denver, Col., 1971; 72 pages, \$1.00.

This little paper-bound pamphlet is a necessary part of the bibliographic background for anyone who needs to be better informed on the problems of the "battered child" and related matters.

The 11 papers which constitute this symposium are introduced by a short preface, and an introductory statement by Vincent De Francis, director of the Children's Division of the American Humane Association, whose keynote address forms an excellent backdrop for the panel discussions. Dr. Francis outlines in general terms the nature and dimensions of the problems to be dealt with in the panel, their implications from the standpoint of victims and the parents, the impact on the community, and the need for developing a coordinated approach to treat and protect children who might be at risk or involved in some of the variable types of child neglect and abuse.

The symposium was co-sponsored by a number of community agencies of the city of Rochester and Monroe County, N.Y., together with the American Humane Association, and presented at the 95th annual meeting of the association in Rochester.

The symposium is divided into three main divisions:

1) "Medical Aspects of Child Abuse," from the viewpoint of the medical social worker, the psychiatrist and the pediatrician, and this division of the symposium is concluded by a helpful review of a "reactor" in which a general summary of this section is discussed.

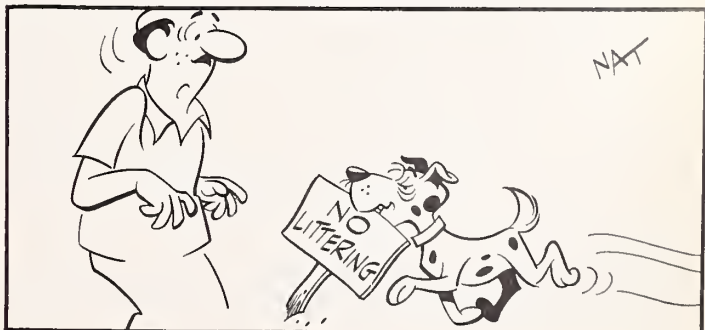
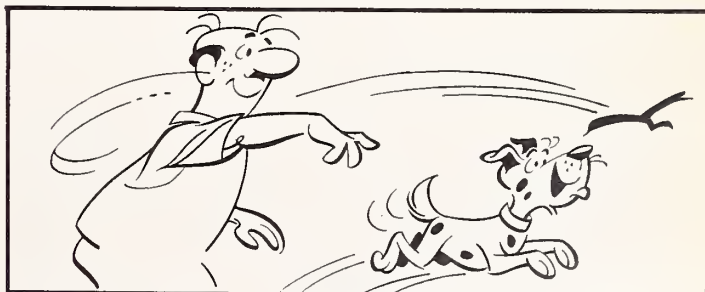
2) The second section deals with the "Protective Service Aspects of Child Abuse," and in it the responsibilities of the protective services and their roles and functions are dealt with in the light of the experiences of the year 1971.

3) The final section of the symposium has to do with "Legal Aspects of Child Abuse," which deals with due process in child protective procedures, the role of the court and its problems in processing such cases, as well as helpful comments from the program reactor.

The symposium concludes with questions and answers, and the final section of the brochure contains a most helpful compilation of books, pamphlets, and teaching records which would be of great value to the serious reader, be he a physician, lawyer, social worker, or interested citizen.

In a number of ways, this little pamphlet contains material that is hard to find otherwise, and certainly it makes useful background reference for the medical, legal, and social work professions. The pamphlet, as well as many of the references, is available through the American Humane Association, Children's Division, P.O. Box 1266, Denver, Colorado 80201.

LALL G. MONTGOMERY, M.D.  
Muncie





## BLOOD

Leo Vroman, Doubleday & Company, Inc., The Natural History Press, Garden City, N.Y., Paperback Edition, American Museum Science Books, Edition: 1971; 178 pages, 58 illustrations, \$1.95.

*Blood* was originally published in a hardcover edition by the Natural History Press in June 1967 and, following its enthusiastic reception by the public, has been published in the distinguished series of publications in a paperback edition by Doubleday through the Natural History Press.

This excellent book contains the type of general science information that is increasingly available to the layman who wishes to have an understandable knowledge of scientific matters, particularly having to do with the body and its functions and possible defects. This is the kind of little volume that is an ideal part of the equipment of a physician's waiting room and for science libraries of schools. It also is a delightful "bedside companion" for the interested layman, not to mention the busy general practitioner who will find this a wonderfully helpful type of presentation of the blood which can be adapted to discussions with patients who may be interested in a general way or specifically because of blood problems. It is frequently hard to find a source of information to which the patient can be referred that will not have the general effect of confusing the patient's concept of medical matters, but the author here has approached the very intricate and difficult concept of the blood and its functions in a unique and unusually interesting and enjoyable way.

A most entertaining part of the book is the series of sketches used by the author to enliven and enrich his equally lively and enticing text.

A quotation from a previous review in the "Publisher's Weekly" gives a good impression of this little book "The first and lasting impression of this book is that the author has a truly magic touch—that he could make any subject fascinating . . . While this is a scientific book, it has a lighthearted approach to its subject."

LALL G. MONTGOMERY, M.D.  
Muncie

## A GUIDE TO HEALTH FACILITIES, PERSONNEL AND MANAGEMENT

Robert M. Sloane & Beverly LeBoV Sloane, The C. V. Mosby Co., St. Louis, 1971; 182 pages with numerous charts, diagrams, and photographs, paperback, \$5.95.

The writers of this clearly printed and well illustrated book explain in a short preface that the volume is intended to fill a need for a "formal, concise (source) of information about the functions, personnel, and inter-relationships of health facility personnel and departments" to provide a source of this kind of information for the education of members of the health team.

The authors point out that "many members of this team who are, or will be, in supervisory positions, find that information on effective management, which is designed for the supervisory, is lacking, and this book is intended to fill this gap, to offer some basic information on the growth and development of the health facility, and on automation and computer applications, and to provide a look into the decade ahead for health facilities."

The authors further state that the book is written primarily for the students in many medical and allied health schools, as well as for persons who are now employed in, or associ-

ated with, health facilities at all levels, as well as in all professions and vocations, including the architect, attorney, accountant, consultant, and sales representatives associated with health facilities. It is also a useful source book for high school students who are interested in possible health related careers.

The book opens with a short but interesting history of the development of health facilities, going back to the most ancient times. This is followed by a section dealing with the various health facility departments of an organization which has personnel, functions, organization, and inter-relationships in which the medical staff, nursing staff, medical departments, non-medical professional departments, patient services, business services and physical plant, staff departments, administration, and outside professional relationships are discussed briefly.

A third section deals with the management of health related facilities in general terms and includes helpful and lucid charts and diagrams which add considerably to the usefulness of the volume.

A final section deals with the direction in which automation is taking the health facilities and adding to their practical functional capacities, as well as the methods of utilizing the new techniques which are projected into the 1980s.

There is an Appendix which describes in some detail some of the professional associations which are most intimately involved with health care at the national level—namely, the American College of Hospital Administrators, the American Hospital Association, the American Medical Association, the American Nurses Association, the Public Health Association, and the Joint Commission on Accreditation of Hospitals. There is an additional listing of 18 other health related professional associations.

Finally, there is a well arranged index which adds considerably to the usefulness of the book.

There is no doubt that this book is more of a reference volume than an exhaustive treatise, but it contains a large amount of information which undoubtedly will be useful to students, as well as to the practicing members of the health related fields.

LALL G. MONTGOMERY, M.D.  
Muncie

## CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT

Kempe, C. H.; Silver, H. K.; O'Brien, D.; et al., Second Edition, Lange Medical Publications, Los Altos, Cal.; 1972.

Few departments of pediatrics could produce an authoritative, useful textbook on pediatric diagnosis and treatment without going further than members of the department and close associates. But the Department of Pediatrics of the University of Colorado School of Medicine is, in this reviewer's opinion (based on personal observation), an outstanding department in research, in clinical pediatrics, and in its remarkable faculty. *Current Pediatric Diagnosis and Treatment* is the sort of book I would expect from the University of Colorado's Department of Pediatrics. The authors have struck a remarkable balance by emphasizing not only the common and important, but also the uncommon though still important, to paraphrase their preface. The book is comprehensive and scholarly and, at the same time, eminently practical. It covers the gamut of pediatric diagnosis and treatment in a succinct (but not too succinct) manner. I can recommend this book strongly, not only for pediatricians, but for family physicians, including those internists who fall under this category. The book is attractively



bound in a flexible plastic cover. Its price of \$12.00 is remarkably moderate.

W. D. SNIVELY, JR., M.D.  
Evansville

## MENTAL HEALTH TRAINING AND PUBLIC HEALTH MANPOWER

Stephen E. Goldston, Ed. D., and Elena Padilla, Ph.D., National Institute of Mental Health, Rockville, Md.; 294 pages, (Paper cover) \$2.75.

This book comprises a report of a research project concerning professional public health workers which is derived from 3115 replies to a questionnaire which was sent to all the American citizens who had received a master's degree from one of the 11 schools of public health in the United States during the period 1961 to 1967. This report deals specifically with issues in public health work and indirectly with schools of public health, particularly as to their role in mental health training and the relevance of the educational programs to professional activities of the professional public health workers who participated in the survey.

It is apparent that this research project was based on the idea that mental health concepts, techniques and practices form an important part of public health programs and enhance the effectiveness of public health work, and that mental health considerations should be an essential aspect of the training program of schools of public health. Further, it was apparent that an effort was made to evaluate the concepts of the respondents to the questionnaire as to their evaluation of the training of public health workers and the relative amount of mental health training that they had received and its pertinence to the work they had been carrying on since their graduation.

In the preface to the volume the authors state: "The findings presented in this book are related to larger issues of the American health crisis, viz., health manpower, health expenditures, and the organization and delivery of health services, and to the place of the continuing controversy between the fields of public health and mental health to this crisis. The increased emphasis on health care with a component of prevention, protection, and health maintenance as a part of the scope of public health and the trends toward community mental health, comprehensive health planning, prepayment programs, and comprehensive health service systems bring into closer urgency the need to clarify the interfaces and areas of common or complementary concerns between public health and mental health. Such clarification is a first step toward conceiving and implementing more effective training programs, and organizing services designed for meeting with efficiency the health needs of all population groups throughout the country. This volume is an attempt in that direction."

In this book the analysis of the results of the research are gathered into six sections as follows; Part I deals primarily with the presentation of contextual background for the research findings. Part II describes the characteristics of the graduates of the schools of public health who participated in the study. Part III deals with the respondent's appraisal of the mental health training they had received in their schools of public health and its relevance to their current work. Part IV deals with the respondent's views on the relationship of mental health to public health and place of mental health in public health. Part V deals with the apparent need for further training and improvement in mental health training programs. Part VI is a summary of the research findings with implications for training, service, and curriculum development.

It should be apparent that this report is primarily of interest to those who are involved in education in public health and mental health, and the relationships between these two fields. It is further a considerable source of information as to the general distribution of workers with these types of specific training orientation. The appendices contain a number of analyses of the replies to the questionnaire dealing with many of the factors involved in the training programs in the 11 schools from which the respondents to the questionnaire came. Another part of the appendix contains a statement of the "Criteria and Guidelines for Accrediting Schools of Public Health," which should be of particular interest to those who are contemplating entering these or a related field of health-related training.

This book is not light reading, but is a very considerable gathering of information in what has become an important and rapidly expanding area of public health in all its facets.

LALL G. MONTGOMERY, M.D.  
Muncie

## CALL THE DOCTOR

Polley, R. F. L., Parents Handbooks, Seattle, Wash., 1971.

Dr. Polley's little book, *Call the Doctor*, is a much needed breath of spring in the field of books for parents. Dr. Polley is no advocate of the permissive attitude toward child rearing that has contributed so much to this generation's problems; he writes both with compassion and good sense. The following criticisms can be offered: the book dwells on the infant, to the partial exclusion of the preschool and older child. Likewise, it appears to this reviewer to place too much emphasis on problem children. However, I can heartily recommend it for all parents and, of course, for pediatricians and family physicians to recommend to parents. Dr. Polley's background is that of 20 years of pediatrics rather than that of the academician type who has cranked out so much nonsense about child rearing in years past.

The book is a paperback priced at \$3.00—a real bargain.

W. D. SNIVELY JR., M.D.  
Evansville

## THE INTERNATIONAL HANDBOOK OF MEDICAL SCIENCE

Edited by D. Horrobin and A. Gunn, Second Edition, published in USA by University Park Press, Baltimore, Md. 21202, 1972; 834 pages, \$14.50.

Some half dozen distinguished Britishers have contributed to this updating of a rapidly being accepted elementary Handbook. Sir Macfarlane Burnet has an excellent chapter on cancer immunity. Prof. Karim of Makerere University follows immediately with a splendid discussion of recent advances in prostaglandin research. In Section B we are confronted by concise guide to modern treatment. Here I become more than a mite confused. It is perfectly proper to use generic terms only. However, being an American, I have enough trouble remembering the U.S.A. generics and proprietary equivalents. The British use many terms that I just fail to recognize. I believe that a nice addendum — a glossary, if you will — would be a great help to the reader.

Also, being an American, I take flat exception to such a statement as appears on page 75: ". . . sedative total daily dose should be given in early evening . . . Amphetamines during work hours. . . ." Has this author heard of the "Uppers"



and "Downers" that are the downfall of our younger generation?

The chapter on chelating agents was crisp and incisive. The one on vitamins was a bit skimpy to my taste. On last line of page 287 I saw that BCG gives protection against *Buruli* ulcer. Does the author mean *Bauru* ulcer of leishmaniasis? The chapter on laboratory investigations is very informative with very good, lengthy tables of normal values for blood, urine, spinal fluid etc. I might disagree with the flat assertion that desiccated thyroid has no place in modern therapy but then, mayhap, I'm just showing my age.

In any case, the binding, printing and paper are of unimpeachable quality. This Handbook reaches the audience for which it is intended at a most reasonable price.

ARNOLD LIEBERMAN, M.D.  
New York City

## PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON NOSOCOMIAL INFECTIONS

Sponsored by Center for Disease Control, American Hospital Association and American Public Health Association, published by American Hospital Association, 1971; 334 pages with many illustrations, \$1.50.

Hospital infections have been a source of great concern since the earliest recorded times. In spite of modern facilities and greatly expanded knowledge of infections and their sources and methods of control, hospitals and similar institutions continue to be faced with problems which are a constant threat to

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patient welfare and require continuing efforts at possible means of control.

Because of their community of interest in the problems related to hospital infections, the American Hospital Association, the American Public Health Association and the Center for Disease Control of the United States Public Health Service collectively sponsored The International Conference on Nosocomial Infections which was held at the Center for Disease Control in Atlanta, Ga., August 3-6, 1971. The conference was intended to bring together a relatively large number of individuals who had been working on the problems related to hospital infections, so that they could share their common experiences and knowledge of the epidemiology of nosocomial infections, with the possibility of identifying effective systems of reducing, controlling, and preventing such infections, and laying out proposed lines of future investigation. Although the majority of the participants were from the United States, there was distinguished participating representation from Canada, England, Sweden, Denmark, Israel and Yugoslavia.

It was pointed out in a short foreword by the co-editors of the proceedings, Dr. Philip S. Brachman and Dr. Theodore C. Eickhoff, that it was apparent to the participants at this conference that a great many specific questions are yet to be answered. On the other hand, it was apparent that the conference developed a highly informed and well organized pool of presently available methods which would undoubtedly reduce the morbidity, mortality and economic loss that now stem from hospital-acquired infections.

The conference was opened by a keynote address by Dr. R. E. Earl Williams, professor of bacteriology and dean of St. Mary's Hospital Medical School of the University of London, England, who set the stage for the remainder of the conference by discussing "Changing Perspectives in Hospital Infection." Dr. Williams also concluded the conference with a lucid and helpful summary of the symposium.

The final chapter in the proceedings consists of the banquet address on "Nosocomial Infections and the Law" by Attorney Crawford Morris of Cleveland.

The body of the conference consists of several significant groupings of the various papers which were presented by the participating discussants over the three-day period, introduced by a section consisting of reports of the "Current National Patterns" by essayists from Denmark, Canada, Yugoslavia, Israel, Great Britain and several from the United States.

Other groupings of the papers were gathered under the categories of Microbial Factors, Emerging Pathogens, Host Susceptibility, and Sources of Nosocomial Organisms. Other sections of the report deal with air control techniques, and other methods of controlling microbial contaminations. The final sections contain a survey of various systems for accomplishing the necessary controls.

This inexpensive and well arranged set of highly authoritative discussions of an extensive array of factors involved in institutional infections is a gold mine of information for hospital administrators, medical staff committees on hospital infection controls, pathologist, microbiologists, nurses, and many other members of the hospital team who participate in the various functional elements of hospital infection controls. This volume also is an excellent teaching tool, and will find a place in the library of almost any of the schools of health-related fields.

As a source of general information to all those interested in hospital infections, the proceedings contain, attached to practically every one of the nearly 100 papers, lists of references



which compose a highly selected and sophisticated background for the entire conference, as well as an extremely valuable source of additional reference material for those wishing to delve more deeply into the various areas covered in the conference.

This is not "bedside reading" but a volume which should be available in reference libraries for members of the health team at any level.

LALL G. MONTGOMERY, M.D.  
Muncie

THE MERCK MANUAL

12th Edition—David N. Holvey M.D., editor, Published by Merck, Sharp & Dohme Laboratories, 1972; 1964 pages, 24 sections, excellent index, over 140 contributors, over 400 specific prescriptions, thumb indexed.

By using specially selected bible paper, the publishers have managed to maintain the traditional handbook size of this splendidly updated primer on diagnosis and therapy and all round rapid reference volume. At \$8.00 the price has been kept at an almost ridiculously basic level.

Some new topics inserted in this edition are coronary care unit, cardiac catheterization, rheumatic valvular heart disease, gynecological malignancies, breast diseases and genetics. Many subjects have been so totally rewritten as to be all but new.

The language has been kept uniformly clear, incisive and comprehensible at almost all levels of medical competence starting from the student nurse and right up to the teaching staff professor. Nowhere have I noticed any effort at pedantic pedagogy or logorrhea.

The new tables are up to the usual standards. The binding printing and editing have been superb. This volume can be unqualifiedly recommended for use by all strata of the medical profession. Congratulations!

ARNOLD LIEBERMAN, M.D.  
New York City

MYOCARDIOLOGY—RECENT ADVANCES IN STUDIES ON CARDIAC STRUCTURE AND METABOLISM—

Edited by E. Bajusz and G. Rona — University Park Press; Baltimore, 1972; \$29.50, 835 pages with countless illustrations and up-to-date references closing each chapter.

More than a hundred leading authorities have contributed to this monograph which is labeled Volume I. Volume II will be titled "The Cardiomyopathies." It is most sobering (for one who rather fancied himself as keeping reasonably up to date) to find whole chapters grueling, hard studying! So much that is really *new*!

It would be gilding the lily were I to stress this section or that. Suffice to say that I reverted to my undergraduate days; I read through, chapter by chapter, trying to correlate, absorb and then see the immense new vistas being opened.

This monograph is a thrilling must for the cardiologist and even the usual board diplomate in medicine. I recommend it highly for the general practitioner trying to understand the new and the different. I'm sure that teachers of medicine will have their students digging into this tough terrain.

As always, the typing, printing and paper are of the highest quality. I noted only a few scattered typo errors. I'm thrilled with anticipation of the Volume II that is heralded as coming

out in the coming year.

ARNOLD LIEBERMAN, M.D.  
New York City

Abstracts From Various Literature, Prepared by AMA

EFFECT OF DIETARY CHOLESTEROL ON SERUM CHOLESTEROL IN MAN

F. H. MATTSON et al. (B. A. ERICKSON, Evangel College, Springfield, Mo. 65802) *Am. J. Clin. Nutr.* 25:589-594 (June) 1972.

In 56 subjects, oral ingestion of cholesterol resulted in elevation of the serum cholesterol. This increase was linear over the entire range of sterol feeding. Each 100 mg cholesterol in 1,000 calories of diet resulted in approximately a 12 mg/100 ml increase in serum cholesterol.

IMMUNOLOGICALLY COMPETENT ANESTHESIOLOGISTS

D. L. BRUCE (Northwestern Univ. Medical School, Chicago 60611) *Anesthesiology* 37:76-78 (July) 1972.

Lymphocyte cultures were prepared from blood of six anesthesiologists and six male graduate students with no history of recent exposure to anesthetics. Stimulation of lymphocytes by phytohemagglutinin (PHA) was assessed by determining uptake of the DNA precursor, thymidine, 72 hours following the addition of PHA. The lymphocytes from the anesthesiologists were normally reactive to PHA. No support was provided for the hypothesis that occupational exposure to anesthetics causes immunosuppression among anesthesiologists.

EARLY MOBILIZATION AND DISCHARGE OF PATIENTS WITH ACUTE MYOCARDIAL INFARCTION

D. McC. BOYLE et al. (J. M. BARBER, Ulster Hosp., Dundonald, Belfast) *Lancet* 2:57-59 (July 8) 1972.

In a hospital coronary-care unit, 18% of patients with acute myocardial infarction were discharged by the seventh day and 62% spent 10 days or less in hospital. The subsequent mortality and readmission rate suggest that early discharge was not harmful. Significant ventricular arrhythmias in the first 48 hours, sinus tachycardia, persistent ST-segment elevation, and recurrent ischemic pain or recurrent arrhythmia were all associated with increased mortality.

IRREVERSIBLE RENAL FAILURE SECONDARY TO HYPERTENSION INDUCED BY ORAL CONTRACEPTIVES

B. J. ZACHERLE (USPHS Hosp., San Francisco 94118) and J. A. RICHARDSON *Ann. Intern. Med.* 77:83-86 (July) 1972.

Oral contraceptive therapy was responsible for two episodes of severe hypertension in a young woman. On the second occasion she developed malignant arteriolar nephrosclerosis that progressed to end-stage renal failure before the contraceptive therapy was stopped. After maintenance hemodialysis, bilateral nephrectomy, and kidney transplantation she is well and requires no antihypertensive medications.



## HOW FAR DO BACTERIA TRAVEL FROM EXHALATION VALVE OF IPPB EQUIPMENT?

E. D. DYER and D. E. PETERSON (VA Hosp., Salt Lake City 84113) *Anesth. Analg.* 51:516-519 (July-Aug.) 1972.

The distances emissions travel from the exhalation valve of IPPB equipment were studied. The Bennett PR2 and the Bird Mark 7 machines were studied separately. Colonies of the challenge organism, *Serratia marcescens*, were recovered 100% of the time on the floor directly under the exhalation valve and repeatedly even at distances of 32 feet, the greatest distance studied. Exhalation valves should be equipped with a bacteria-restraining device, either by manufacturers of such equipment or by hospital personnel responsible for patient care. Until this is done, IPPB therapy should be administered in a separate room by personnel wearing effective face masks.

## FIRST AID TREATMENT OF ELECTRIC SHOCK

R. MORLEY (Dept. of Electrical Engineering, Univ. of Newcastle upon Tyne, Newcastle upon Tyne, England) and A. O. CARTER, *Arch. Environ. Health* 25:276-285 (Oct.) 1972.

Investigations and postmortem examinations of 82 electrocutions were made in the north of England and 7,724 electrical accidents occurring in England, Scotland, and Wales were reviewed. The efficiency of the first aid treatment given was evaluated. Two blows on the precordium at the commencement are recommended. External cardiac massage by nonmedically qualified persons is not recommended in electric shock. Mouth-to-mouth resuscitation is not recommended in electric shock. Preference is expressed for a manual method of artificial respiration.



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Mallinckrodt/Nuclear has published a 20 page mini-review of current in vitro test procedures for thyroid function. Tests discussed are PBI, the Res-O-Mat T3, T4 and FT4, and the new Res-O-Mat ETR (Effective Thyroxine Ratio). The latter is not affected by exogenous iodine or by the effects of birth-control medication or pregnancy. The free booklet is available from Mallinckrodt Chemical Works, 675 Brown Road, Hazelwood, Mo. 63042.

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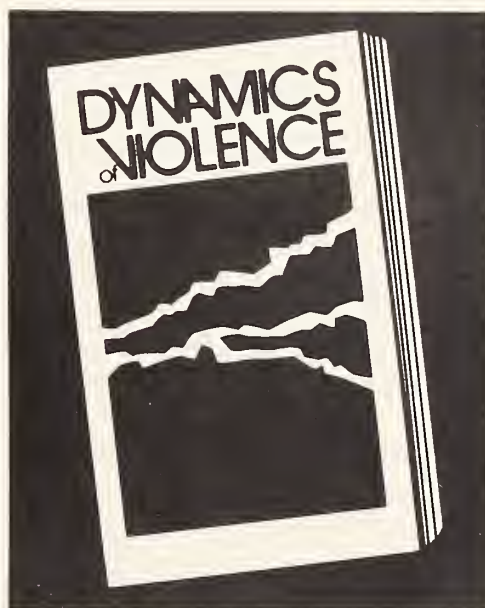
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Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone





infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

## Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.







Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections.

Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:

Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg Pediatric Capsule ..... 250 mg  
500 mg Capsule ..... 500 mg  
\*Sterile Solution per 1 ml ..... 300 mg  
Syrup per 5 ml ..... 250 mg

\*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rash, urticaria, vaginitis, and rare instances of erythematous and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg and 500 mg Capsules—bottles of 24 and 100. Sterile Solution, 300 mg per ml—2 and 10 ml vials and 2 ml syringe. Syrup, 250 mg per 5 ml—60 ml and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-6-S (KZL-7) JA71-16

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Kalamazoo, Michigan 49001

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# FUTURE MEETINGS, SEMINARS, COURSES

## Clinic Announces Four Programs

The Cleveland Clinic Educational Foundation will conduct a Clean Air Symposium on November 10, and a postgraduate course on gastroenterology on November 15 & 16. The fee for the Symposium is \$30, for the postgraduate course \$60. Address the Foundation at 9500 Euclid Ave., Cleveland, Ohio 44106.

A postgraduate course on "Current Concepts in Ophthalmology" has been announced for December 6 and 7, while "Geometric Total Knee Arthroplasty" has been set for December 8. Fees: \$60 and \$30, respectively.

## Northwestern to Host Symposium

A Symposium in Renal Disease, Hypertension, and Fluid and Electrolyte Balance will be held at the Northwestern University Medical Center, Chicago, December 4 to 8. This is an intensive 5-day postgraduate course for internists, surgeons, and general practitioners. AAFP accreditation applied for: 30 hours. Advanced registration is required. There is no registration fee. Write Frank A. Krumlovsky, M.D., 303 E. Superior St., Chicago 60611.

## Conference at Kentucky on Pediatric Ophthalmology

The University of Kentucky at Lexington will conduct a Pediatric Ophthalmology Conference on December 15 and 16. The fee is \$75 for practitioners, \$10 for residents and fellows. Write Frank R. Lemon, M. D., University of Kentucky, Lexington.

## International Authority to Speak at Myers Auditorium on Dec. 6

Dr. Simon Sevvitt, an internationally known authority on venous thrombosis and pulmonary embolism, will speak on the subject Wednesday December 6, 1972 at 1:30 P.M. in the Myers Auditorium of Marion County General Hospital. Following his presentation Dr. Sevvitt will serve on a panel with representatives of the Department of Medicine, Surgery, and Orthopaedics to discuss case presentations from 3-4:30 P.M.

Dr. Sevvitt, Consultant Pathologist of the Birmingham Accident Hospital, Birmingham, England, has recently co-authored a major book on the subject of venous thrombosis and pulmonary embolism and is known for similar publications in the field of fat embolism, burns, and fracture healing.

The medical public is invited to hear this outstanding speaker.

## Gastrointestinal Problems Norton Infirmary Subject

The Fifteenth Annual Norton Postgraduate Medical Seminar will focus on "Current Management of Difficult Gastrointes-

tinal Problems." A panel of distinguished speakers has been arranged for the December 14 meeting which will begin at 10:00 a.m. and end about 4:00 p.m.

The program is approved for five prescribed credit hours by the American Academy of Family Physicians.

Reservations may be made by writing the Infirmary at P.O. Box 655, Louisville, Ky. 40201.

## 14th PG Course Set for 11-Day Cruise on Ship

Department of Postgraduate Medicine of Albany Medical College announces the 14th Postgraduate Medical Seminar Cruise, January 5 to 22. An 11-day cruise from New York on the "Gripsholm" with a comprehensive shipboard postgraduate program. Write Frank M. Woolsey, Jr., M. D., Albany Medical College, Albany, N. Y. 12208.

## Department of Surgery Offers Course at Miami Beach Hotel

The University of Miami School of Medicine will conduct a postgraduate seminar in "Art and Science in the Therapy of Difficult Problems in Surgery" at the Eden Roc Hotel, Miami Beach, January 10 to 13. The fee is \$125. Write Department of Surgery, University of Miami School of Medicine, Jackson Memorial Hospital, P. O. Box 875, Biscayne Annex, Miami 33152.

## Symposium on Polytomography Of the Temporal Bone Offered

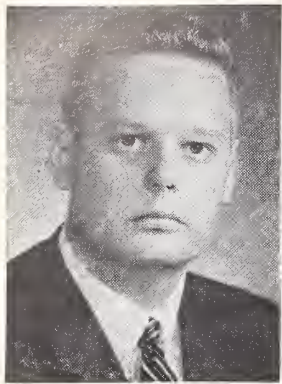
The 6th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, on February 3 and 4, 1973.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is \$150.00.

Inquires should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis 46219.





## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THE I.R.S. intends to carefully examine taxpayers' income tax deductions for business trips and business conventions. The reason for the special audit effort is because too many professional, business, and trade association have been sponsoring trips and conventions during which only a small portion of the time is devoted to business activity. However, several executive directors of professional associations have told me that trips and conventions that are scheduled "out of state" generally significantly increase the attendance at business meetings, particularly from the young persons—i.e., the very persons that the associations are attempting to woo. However, in order to insure your deductions for professional trips and conventions, you should request that the executive director of your association (or other tour arranger) consult a lawyer concerning the income tax aspects of the trip.

In Rev. Rul. 72-3, the I.R.S. ruled that a pension plan is not a qualified plan if the pension benefit for a participant exceeds the highest average salary that the participant earned (covering any reasonable service with the employer). While the Internal Revenue Code does not specifically provide this limitation, most employers (and employees) probably do not want to litigate the issue. Therefore, you would be wise to have your lawyer examine your pension plan—with this new ruling in mind.

Many of you will be happy to know about two recent I.R.S. rulings that describe the conditions under which political contributions may be deducted (or used as credits) for federal income tax purposes. These contributions include payments for tickets to dinners, dances, or other social events, and for chances on raffles. Rather than paraphrase the I.R.S. pronouncements, I suggest that you ask your lawyer to send you copies of Rev. Rul. 72-411 and Rev. Rul. 72-412.

Watch out for the situation in which you are about to contribute non-income-producing property to a trust. In a recent case, the court held that two donors could not benefit from the federal gift tax exclusions for stock in a family corporation that they gave to a trust. The main reason for the denial was because the value of the stock was unascertainable—due to the fact that the stock was non-income-producing property—i.e., it was unlikely that the corporation would declare dividends. Thus, have your lawyer compare your facts with those in *Stark*, DC.Mo., CCH §12,-877 (1972) before you make such a transfer.

Case after case is holding that the various amounts that are paid to interns by hospitals are taxable as compensation for services rendered, and not excludable from gross income as a fellowship. Therefore, it would be most unwise for an intern to exclude from his gross income any amounts or services paid or otherwise furnished to him by a hospital—without first consulting his lawyer. For a recent case, see *Hembre, Jr.*, CCH §9607 (CA-4 1972).

The I.R.S. will increase its audits of income tax returns when it employs the 900 new employees that now have been authorized by Congress.

For years, I have been telling my students to watch, when they visit a race track, the big winners reach down and pick up discarded race betting tickets. The reason for the scooping up of losing tickets is because I.R.C. section 165 allows a gambler to deduct gambling losses to the extent of his gambling gains. However, the courts have now become aware of this practice, and, in a recent amusing case, the Tax Court Judge carefully examined the gambler's losing tickets. And, after seeing too many footprints on the tickets, the judge denied most of the gambler's losses.

If any of you are unsecured creditors of the Penn Central Transportation Company, then ask your lawyer to send you a copy of *Treas. Rel. I.R.-1242* (7/20/72). Basically the release states that such creditor may consider, for income tax purposes, the amounts that were due them as being worthless as of June 21, 1970. Thus, some of these creditors may be entitled to federal and state income tax refunds.





# You get just about the same headroom and legroom in a \$3,600 Audi as you do in a \$23,800 Rolls-Royce.

The Audi isn't a very big car. On the outside.

But don't let that fool you about the size of the car on the inside.

You'll find there's more headroom than you'd ever expect. Enough for, say, a person 6'6". And if he's got unusually long legs (which a person of his size usually has) he won't have to sit clutching his knees. Because there's more legroom than you'd ever expect.

Mind you, he's not the only one who would sit comfortably. The Audi can seat a family of five rather nicely.

Now the \$23,800<sup>†</sup> Rolls-Royce isn't the only great car the Audi has a lot in common with.

The Audi has rack-and-pinion steering just like the Ferrari 512 racing car. And front-wheel drive just like the Cadillac Eldorado.

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the Porsche 917 racing car. And the same amount of trunk space as the Lincoln Continental.

Our interior looks so much like that of the Mercedes-Benz 280SE, you can hardly tell them apart.

And as for service, you'll get the same kind of expert service a Volkswagen gets. Because a Porsche Audi dealer is part of the VW organization.

Impressed? You should be. After all, the Audi bears a startling similarity to some of the world's finest automobiles.

But what makes the Audi especially impressive is its price tag.

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\*Suggested retail price East Coast P.O.E. \$3595. Local taxes and other dealer delivery charges, if any, additional.

<sup>†</sup>Manufacturer's suggested retail price. Local taxes and other dealer delivery charges, if any, additional.

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### Lichtsinn Imports

9825 Indianapolis Blvd., Highland

### Kline Porsche Audi, Inc.

5158 North Keystone Ave., Indianapolis

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## Removal from Market of Hundreds of Rx Drugs Possible in Court Case

Generally unnoticed in the medical press, a recent court decision could result in the removal from the market of scores — perhaps hundreds — of drugs of significant value to prescribers and the public.

In 1970, the American Public Health Association and the National Council of Senior Citizens sued the Food and Drug Administration demanding that it remove pharmaceutical products marketed prior to 1962 unless they have been proven effective in clinical trials acceptable by 1972 standards. The National Academy of Sciences/National Research Council review of most 1938-1962 products found that most of the products had not been subjected to the sophisticated testing now current, and therefore rated most of them either "probably effective" or "possibly effective," on the basis of the available studies and the panelists' opinion. FDA, following receipt and study of the NAS reports, has permitted manufacturers to either cease the marketing of such drugs, eliminate or amend claims that had been judged questionable, or begin additional tests designed to establish the previously inadequately documented claims.

The effect of the court decision could be to summarily remove all such drugs from medical practice. Although there is a legal provision for public hearings before such drastic action, FDA has not granted a public hearing over the removal of a drug from the market in years.

In deciding in favor of the plaintiffs, District of Columbia Federal Judge Bryant castigated FDA for "intolerable procrastination" in processing the NAS/NRC reports, and for what he considers evidence of "solicitude" for the drug manufacturers.

The judge ordered lawyers for FDA and the APhA to draw up a suggested Order implementing his decision. The final Order is expected momentarily. If it follows the Judge's earlier decision it will be imperative that FDA appeal the decision. At that time an Amicus brief will be filed by the PMA on behalf of the pharmaceutical industry. Hopefully, a similar action on behalf of practicing physicians will be taken by one or more national medical associations. — **From National Pharmaceutical News, Sept. 1972. Reprinted with permission.**

## Two Manuals on Portable Fire Extinguishers Offered

The National Fire Protection Association announces publication of two 36-page manuals, both on sale for \$1.25 each. NFPA No. 10 is "Standard for the Installation of Portable Fire Extinguishers." NFPA No. 10A is "Recommended Good Practice for the Maintenance and Use of Portable Fire Extinguishers." Booklets may be purchased by writing the Association at 60 Batterymarch St., Boston, Mass. 02110.

## Lilly Sets Up New Division

Eli Lilly and Company has established a new division, Dista Products Company, for the marketing of prescription pharmaceutical products in the United States. The initial Dista line will include a number of Lilly products which will be transferred to the new company and distributed under existing product trademarks.

## Attend ASIM Meet in Las Vegas

**Drs. R. Edmund Storey**, president, and **Robert L. Rudesill**, president-elect, of the Indiana Society of Internal Medicine, were delegates to the American Society of Internal Medicine Interim Meeting at Las Vegas, Nev., September 29 and 30.

## NFPA Publishes New Booklet On Sprinkler System Standards

"Standard for the Installation of Sprinkler Systems" is a new 192-page book published by the National Fire Protection Association. New material brings the book up to date, especially for high-rise buildings. The price is \$2.50. Address the Association at 60 Batterymarch St., Boston 02110.

## Surgical Pathology Models Offered

William C. Swatek, M. D., pathologist of Pontiac, Mich., is offering surgical pathology models for teaching purposes. Each is documented and labeled. Any tax exempt, non-profit institution may obtain the models gratis. Write Box 380, Pontiac, Mich. 48055.

## VA Installs Betatron Generator

The Veterans Administration announces the installation of the latest model of the Betatron generator in the VA Bronx Hospital. It produces high energy electron beam and gamma radiation. It is capable of firing 25 million volts of radiation from each of two ports for simultaneous treatment of surface and deep-seated cancer. The machine generates so much heat that a 10-ton air conditioner is necessary.

## Rural Hospital Seminar Scheduled in Three Parts

A three-part Rural Hospital Seminar on "Hospital Services in Rural Indiana—Challenge and Opportunity" will be conducted at Stouffers Indianapolis Inn on December 6, January 17 and June 13. Each of these days is Wednesday.

The sessions will discuss "Problems," "Solutions," and "Proposed Implementations." The seminars are sponsored by the Indiana Academy of Family Physicians, Indiana Hospital Association, Indiana Regional Medical Program, Indiana State Board of Health, the ISMA, Indiana University School of Medicine and the Indiana Association of Public Health Physicians. All interested physicians are invited to attend.

Write to Indiana Public Health Foundation, 1330 W. Michigan St., Room A-102, Indianapolis 46206.



## Medical Staff Officers Chosen

New officers have recently been named by the medical staff of three hospitals.

**Dr. Alton Ridgway, Lapel**, became chief of staff of River-view Hospital at Noblesville on September 1, and **Dr. Joe R. Lloyd, Noblesville**, secretary-treasurer.

At Welborn Memorial, Evansville, the following officers were elected: President, **Dr. William C. Grimm, Jr.**; president-elect, **Dr. E. Gregg Sheehan**; secretary, **Dr. John F. Lawler**; executive committee, **Drs. L. H. Downer, I. R. Hargett and Jack O. Williams**.

At Lutheran, Fort Wayne, Dr. Lloyd Vogel has become president, with Dr. Fred Dahling, New Haven, named president-elect. Other officers serving the medical staff for the year are Dr. Allen Aldred, secretary, and Dr. Alan Richards, treasurer. Also on the Executive Committee are Dr. Herbert Acker, chairman, Dr. Donald Ladig, Dr. Robert Flaherty and Dr. Cecil McEachern.

## Elected to ITAA

**Dr. Donald L. McKinney, Otterbein**, has been awarded advanced membership in the International Transactional Analysis Association. He is on the faculty of the Halcyon Institute, which operates at the Wabash Valley Hospital's Mental Health Center, as is **Dr. Edgar C. Stuntz, Lafayette**, who is a provisional teaching member of the ITAA.

## Dr. Flanagan Speaks on Alcoholism

**Dr. Paul M. Flanagan**, medical director of Corneila Cole Fairbanks Hospital, Indianapolis, spoke on "Alcoholism in Industry" at the September meeting of the Mid-Indiana Association of Industrial Nurses.

## Opens New Illinois Office and Lab

White-Haines Optical Company announces the opening of a new branch office and prescription laboratory in Danville, Ill. The company also has a newly constructed facility for its Grand Rapids, Mich. operations. Branch operations now include 39 cities in 8 states.

## Tells of Appalachia Stint

**Dr. Floyd M. Rheinheimer, Milford**, told the Milford Lions Club recently about a six-week stint of duty he served at the Daniel Boone Clinic in the Cumberland Gap area of Appalachia.

## NRA Appoints Dr. Koenig

**Dr. Harold Koenig, Rockville**, has been appointed a certified rifle instructor by the National Rifle Association of America. He is now qualified to conduct classes in basic marksmanship and safe gun handling.

## Slaughters Featured in AMA News

An article in a recent issue of the *American Medical Association News* on large medical families featured the Slaughter family, three of whose members practice at Evansville: **Drs. Howard C.**, an ophthalmologist, **John C.**, a dermatologist, and **Owen L.**, a specialist in internal medicine and cardiology.

Another brother, **Dr. Wayne B. Slaughter**, is a plastic sur-

geon in Chicago. Two other brothers are deceased: Earl Slaughter, M.D., an otolaryngologist, and Guy Slaughter, M.D., an obstetrician, both of whom practiced in their hometown of Norfolk, Neb.

## AMA Medical Journalism Awards

The AMA has announced that it will make its \$1,000 Medical Journalism Awards for 1972 to winners in five classifications — newspaper, magazine, editorial, radio and television. Doctors are asked to urge any individuals who have been distinguished during 1972 for medical reporting which has brought the public a better understanding of health and medicine to make applications for the Award. The deadline is February 1, 1973. Doctors may write John C. Vivian, 535 N. Dearborn, Chicago 60610 to request that full particulars be sent to likely candidates.

## ACP Elects Dr. James Lewis

**Dr. James Lewis, Richmond**, has been elected to membership in the American College of Physicians.

## Laboratory to Be Named For Dr. Francis W. Porro

The new pathology laboratory at St. Mary's Hospital, Evansville, will be named in honor of **Dr. Francis W. Porro**, who retired recently as chief pathologist on the hospital staff. He had been in charge of the laboratory since 1949.

A Senior Member of the Indiana State Medical Association, Dr. Porro is a diplomate of the American Board of Pathology and observed his 71st birthday in September by attending the world congress on pathology in Munich.



"IN GRATEFUL APPRECIATION of six years of loyal service as Trustee of the 13th District of the Indiana State Medical Association, 1965-1971" was inscribed on the plaque recently presented to Dr. Otis Bowen by Mrs. G. Beach Gattman, for the district society. The plaque had been presented formally by Dr. George Haley at the District Meeting on September 13, but Doctor Bowen wasn't present to receive it on that occasion. Later, when the new Trustee, Doctor Gattman, was scheduled to hand over the plaque, Doctor Gattman was unable to be present, so Mrs. Gattman did the honors.



Continued

### Dr. McCalla Has Part in Play

Dr. Charles X. McCalla, Paoli, played the part of General Bullmoose in four performances of "Li'l Abner" when it was given recently by the Orange County Players.

### Wins Ames Award

Dr. Ralph E. Thiers of the Bio-Science Laboratories of Van Nuys, California, was awarded the Ames Clinical Chemistry Award for 1972 by the American Association of Clinical Chemists. The award was originated by and is presented annually by the Ames Company of Elkhart.

### Named Editor of MEDCOM

Dr. George W. Thorn, retiring head of Medicine at Peter Bent Brigham Hospital, has been appointed Editor-in-Chief of MEDCOM, Inc., the producer of educational and training material for medical use. His function will be to coordinate the work of hundreds of medical authorities who participate in the construction of teaching material.

### Incinerator Safety Booklet Offered

The National Fire Protection Association announces a new booklet on current equipment and installation practices for incinerators. The 32-page booklet is revised and updated. Its title is "Standard on Incinerators and Rubbish Handling." Price is \$1.25. Write the Association at 60 Batterymarch St., Boston 02110.

### ACS Elects 15 Hoosier Members

There were 15 Hoosiers among the 1527 surgeons who were inducted as Fellows of the American College of Surgeons at the recent ACS Clinical Congress in San Francisco. The initiates from Indiana are:

Anderson: Drs. Lawrence E. Allen, William J. Tierney.

Evansville: Dr. Ronald W. Sowa.

Fort Wayne: Dr. George W. Bowers.

Indianapolis: Drs. Julius M. Goodman, Gilbert T. Herod, David H. Markstone, Frederick G. Winegarner.

Jeffersonville: Dr. Gordon L. Gutmann.

Munster: Drs. Richard P. Auburn, Arthur M. Branco, Charles E. Helms.

South Bend: Dr. John R. Cassidy.

Terre Haute: Dr. Vicente G. Sison.

Vincennes: Dr. John N. Haswell.

### Offers New Pamphlet on Rights of Teenage Patients

Public Affairs Pamphlet No. 480, available now at 35 cents per copy, is entitled "The Rights of Teenagers as Patients." Thorough discussion of the problems of medical treatment without parental knowledge or consent. Address Public Affairs Committee, 381 Park Avenue South, New York City 10016.

### Named AMA Representative

Dr. Lowell Steen, Hammond, has been appointed AMA representative to the National Council for Homemaker-Home Aide Services, Inc.

★

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# *Annual Meeting Dates of Professional Medical and Allied Organizations*

## **AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**

**Date** Nov. 26-29, 1972  
**Place** Cincinnati

## **INDIANA STATE MEDICAL ASSOCIATION CONVENTION**

**Date** October 6-11, 1973  
**Place** Indianapolis

## **NORTHERN INDIANA PSYCHIATRIC SOCIETY**

**Date** Fourth Wednesday of every  
month, September through June  
**Place** For location and program, inquire  
Jon Leipold, M.D.,  
919 E. Jefferson Blvd.  
South Bend 46622

## **INDIANA ACADEMY OF FAMILY PHYSICIANS**

**Date** April 2-5, 1973  
**Place** Indianapolis Stouffer's Inn

## **INDIANA PSYCHIATRIC SOCIETY**

**Date** Second Wednesday of September,  
November, January, February,  
March and April  
**Place** For time and place, inquire Wes-  
ley A. Kissel, M.D., 1815 N.  
Capitol Ave., Indianapolis 46202

## **INDIANA DENTAL ASSOCIATION**

**Date** May 14-18, 1973  
**Place** Indianapolis Convention-  
Exposition Center

## **INDIANA CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS**

**Date** May 3-5, 1973  
**Place** Indianapolis, Hilton

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### **Closed Circuit TV and Video Tapes Available**

The Medical Education Resource Program (MERP) of the I.U. School of Medicine operates WAT-21 Closed Circuit Medical Education Television Network in 20 community hospitals around Indiana. The network airs programs 5 hours a day 5 days a week. MERP also operates a videotape network in 53 community hospitals which has access to several of the same programs shown on WAT-21.

For information on either network contact Mr. Don Greene or Miss Sharon Chenoweth at 317-264-7212, Medical Education Resource Program, I.U. School of Medicine, 1100 W. Michigan Street, Indianapolis 46202.

### **Comprehensive Library Service Offered**

The "Indiana Biomedical Information Program" brings the resources of the Medical School Library into 85 Indiana communities. Through this program articles are available to physicians outside Marion County simply by using the toll free number or terminal.

For further information contact your hospital librarian or Miss Mary Jane Laatz, Medical Librarian, I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202; 317-264-7182.



# *The Woman's Auxiliary* REPORTS TO ISMA

An invitation to attend an Alcohol Countermeasures Forum at Michigan State University early in September was accepted with pleasure. I was one of 20 women from Indiana invited to attend the six-state forum for Women Highway Safety Leaders as a guest of the Hoosier Motor Club and the Triple A.



This was a most informative session — we attended two days of intensive, in-depth studies of the relationship of the drinking driver and highway safety.

A number of resource people presented material on various aspects of highway safety, including such subjects as Blood Alcohol Level and a breathalyzer demonstration by members of the Highway Traffic Safety Center at MSU and the Michigan State Police. Later in the day, we heard a discussion of the Implied Consent Law by Mr. Wantland Sandel, staff director, American Bar Association Traffic Court Program in Chicago.

The second day, we listened to a panel discuss stepped-up enforcement. The three E's of safety — Engineering, Enforcement, and Education — were presented as a basis for improving highway safety. Lt. Zane Gray of the Michigan State Police told us enforcement involves prosecutors, judges and citizens. If there is no support, enforcement is ineffective. Michigan has recently received a \$300,000 grant to be used to increase police coverage in high accident areas. They are employing police officers on a voluntary overtime basis to beef up highway patrols. They have worked extra shifts four week-ends so far and have cut traffic fatalities from 33 in July to 17 in August in one such high-risk area.

We also heard speakers on such subjects as Drinking Driver Rehabilitation, Long Term Counseling, Antabuse Treatment, Alcohol Education in the Schools and for the Public. This was a most interesting conference — it really opened ones' eyes to the problems that do exist. But it also pointed up the fact that much research is being done on the problem and several possible courses of action are being presented to us to use for greater highway safety. An Indiana Association of Women Highway Safety Leaders is presently being organized and will soon be able to start the task of disseminating this information within the state.

On September 13, Indiana Health Careers, Inc., held an orientation meeting for state auxiliary members, county presidents and health manpower chairmen. This was to help define the Auxiliary's role in helping to recruit health manpower in the state and explained how Indiana Health Careers, Inc., can help achieve this goal by providing materials to school guidance departments and personnel to assist in conducting workshops in the schools.

October 2, 3, and 4 were spent in Detroit as a guest of the Woman's Auxiliary to the Michigan State Medical Society. Mrs. Robert Beckley, president of the Woman's Auxiliary to the AMA was the keynote speaker. Among the many fine speakers was Dr. Louis Zako, who offered some sobering information on the status of V.D. and some thoughts on how we might become involved in helping to combat the problem.

Pastor Robert Huff of Midland, Mich., was the luncheon speaker. He gave a delightful and provocative talk on "Professional Family Living," citing some of the problems encountered by physicians and their families. One thing we learned was to tell our husbands — often — how great we think they are!

It was a wonderful experience to be able to visit other state auxiliaries. We have an opportunity to observe, to learn and to exchange ideas. And it makes us realize that we have a pretty fine organization in Indiana.

*Marjorie Smith*



# Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

## For more modern anemia therapy

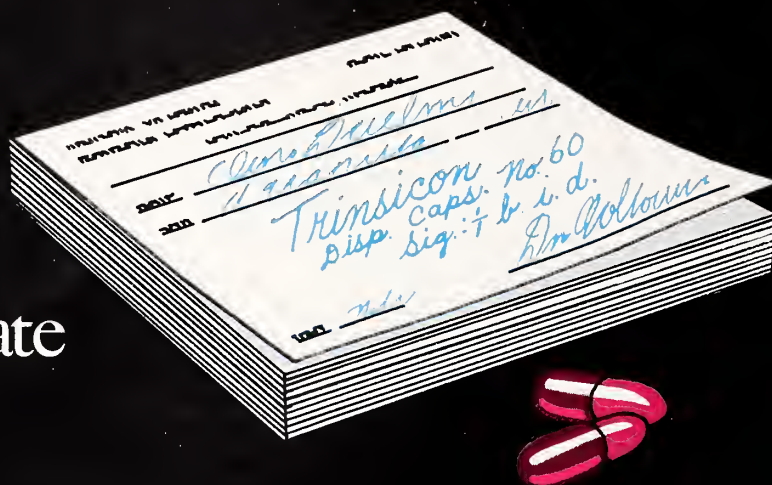
**Trinsicon<sup>®</sup>**  
Hematinic Concentrate  
with Intrinsic Factor

(See reverse side for prescribing information.)



# Trinsicon®

## Hematinic Concentrate with Intrinsic Factor



**Description:** Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly  
 (containing Intrinsic Factor) . . . . . 240 mg.  
 Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 7.5 mcg.  
 (The total vitamin B<sub>12</sub> activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Iron, Elemental (as Ferrous Fumarate) . . . . . 110 mg.  
 Ascorbic Acid (Vitamin C) . . . . . 75 mg.  
 Folic Acid . . . . . 0.5 mg.

**Indications:** Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

**Vitamin B<sub>12</sub> with Intrinsic Factor**—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B<sub>12</sub> in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B<sub>12</sub> leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B<sub>12</sub>. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B<sub>12</sub> deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B<sub>12</sub> contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B<sub>12</sub>) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

**Folic Acid**—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B<sub>12</sub> deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B<sub>12</sub> interrelationship: (1) B<sub>12</sub> influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B<sub>12</sub> progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B<sub>12</sub>.

**Iron**—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

**Ascorbic Acid**—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

**Contraindications and Precautions:** Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B<sub>12</sub>-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B<sub>12</sub> may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B<sub>12</sub>. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

**Adverse Reactions:** In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

**Dosage:** One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

**How Supplied:** Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500 and in Identi-Dose® (unit dose medication, Lilly) in boxes of 100.

(090971)

# Trinsicon®

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**Medical Practice Good Will Considered Community Property**—In a division of property during a divorce action, the good will of the husband's medical practice was included in the wife's community interest in the practice, a Texas appellate court ruled.

The trial court granted a divorce to the wife and divided the property of the parties. The court found the wife's community interest in the medical practice, including good will, to be \$40,000 and ordered the physician to make specified payments to the wife until the entire amount was paid off or until he ceased to practice medicine.

On appeal, the husband, an ophthalmologist, made no complaint about the granting of the divorce or about the division of property other than the part of the division related to the good will of the medical practice.

The appellate court found no previous divorce case appealed in the state involving the question of whether a profession depending on skill, confidence in, and reputation of one person can have good will and if so whether such good will should be considered in dividing the property of the parties. The court did find three cases other than divorce cases where it had been held that a physician might acquire good will as a business asset. In line with those decisions, the court held that a physician could acquire good will in connection with his practice

and that it was an asset and property, even though it was intangible.

The husband and wife had been married for several years before he was licensed to practice medicine. Because the good will was wholly acquired during the marriage, the court held it was community property and should be considered in dividing the property.—*Nail v. Nail*, 477 S.W.2d 395 (Tex. Ct. of Civil App., Feb. 11, 1972; rehearing denied, March 10, 1972).

**Physician Held in Contempt for Failure to Produce Records**—A physician who failed to obey a subpoena to appear in court and bring with him certain records was properly held in contempt, a Florida appellate court ruled.

The physician was subpoenaed to appear in court and testify and to bring with him records pertaining to treatment of a patient involved in a lawsuit. Attorneys for both parties to the suit subpoenaed the physician, and when he failed to appear, the court recessed the case. After the recess, the physician appeared and admitted receiving the subpoenas but failed to give satisfactory reasons for failure to obey them.

The court found the physician in contempt and ordered him to pay a fine of \$300 or serve 30 days in jail. He was given 24 hours to either pay the fine or surrender himself to the jail.

The physician appealed the order of contempt, contending that it violated his right to due process of law and deprived him of his right to written notice of the alleged contemptuous conduct and of a fair opportunity for defense. The court held that the trial judge had followed the proper procedure and that there had been no reversible error. The court said that much time, effort, and money are involved in bringing a case to trial, and the judge has authority to proceed swiftly in dealing with those who disregard his proper orders.

Because the contempt proceedings were instituted to punish for disobedience of a court order, the appellate court held that it was criminal contempt. Criminal contempt may be punished summarily if the court saw or heard the contempt committed. The physician argued that this contempt was not committed in the actual presence of the court. Therefore, the appellate court decided to certify its opinion and decision to the Florida Supreme Court as a question of great public interest.—*Aron v. Huttoe*, 258 So. 2d 272 (Fla. Dist. Ct. of App., Feb. 15, 1972; rehearing denied, March 15, 1972).

**Prominent Attorney Loses Libel Suit; Held to Be "Public Figure"**—

In a libel suit against a publishing company, a prominent attorney was held to be a "public figure" and was therefore not entitled to damages for defamation for published material concerning matters of public interest.

A "public figure," as well as a public official, may recover damages only when there is clear and convincing proof that an alleged libel is made with knowledge that it is false or with reckless disregard as to whether or not it is false. Otherwise, the constitutional guarantees of freedom of speech and freedom



of the press protect a newspaper in libel suits, a federal appellate court held.

The allegedly defamatory statements were made in one of two articles in connection with the attorney's defense of Jack Ruby on charges that he murdered the accused assassin of President John F. Kennedy. Among the statements were assertions that the attorney had tried the case as a personal injury case, rather than a murder case, and that his handling of the insanity plea was incompetent. The attorney sued for \$1,000,000 in general damages and \$1,000,000 in exemplary damages for defamation of character.

In affirming summary judgment for the publisher, the court pointed out that there was nothing to show that the publisher even had any serious doubts as to the truth of the disputed article and that there was no showing of malice under applicable constitutional principles.—*Belli v. Curtis Publishing Company*, 102 Cal. Rptr. 122 (Cal. Ct. of App., May 10, 1972).

**Standard of Care in Telling Patient of Possible Surgical Complication**—In an action for malpractice, no reversible error was committed by the trial court in submitting to the jury the questions of whether a physician was negligent and whether he had obtained a patient's informed consent to a hysterectomy, the highest court of Maryland ruled.

The patient, a 47-year-old woman, had undergone several unsuccessful dilations and curettages because of menstrual difficulties. She consulted a gynecologist because of recurrence of the problems.

The gynecologist decided against use of hormone treatment until a lump in the patient's breast was

evaluated. He referred the patient to a general surgeon. The surgeon recommended that the patient enter the hospital for a biopsy. The gynecologist said if the lump were benign he and the surgeon would perform a hysterectomy. Although he warned that the operation was major surgery and that there could be complications, he said, the patient consented to the procedure.

The growth was found to be benign, and the hysterectomy was performed with no apparent complications. After the patient returned home from the hospital, however, she experienced leakage of urine through her vagina.

The gynecologist discovered a fistula in the bladder and referred the patient to a urologist. The gynecologist and the urologist first thought that a suture might have injured the bladder, but the urologist later decided that a fistula had developed in a weak spot in the bladder wall. Two operations were required to stop the leak.

The patient brought action for malpractice against the gynecologist, contending that he had negligently injured her bladder during the operation, that he had improperly delayed postoperative treatment until she told him of the leakage, and that he was negligent in failing to inform her adequately of the risks of the operation and the possible alternatives to surgery.

At the trial, an expert testifying for the patient said that a physician would be negligent if he placed a suture in the bladder during a hysterectomy and did not recognize and correct the condition immediately. He also said that the gynecologist did not adhere to the standard of care when he did not inform the patient of all possible complications and risks involved before obtaining her consent to the operation.

Experts testifying for the gynecologist agreed that leaving a suture in the bladder would be negligent, but they did not believe this had happened in the present case. They thought the probable cause of urine leakage was a thin bladder wall, which had been further weakened by the operation. They also said it was not standard procedure for a physician in the community to do more than advise a patient that a hysterectomy is major surgery, with possible risks and complications.

The jury brought in a verdict for the gynecologist. On appeal, the patient questioned the trial judge's instructions to the jury regarding the question of whether the gynecologist deviated from the standard of care by not informing her sufficiently. One of the issues submitted to the jury was whether the gynecologist had obtained the patient's consent through misrepresentation.

The patient said she had conceded that the gynecologist did not deliberately lie or intentionally misrepresent the facts in order to obtain her consent. Therefore, she thought that her case before the jury was prejudiced by the suggestion that she was making such contention.

The appellate court held that, although submission to the jury of the issue of deliberate concealment was unnecessary, it could not have been detrimental to the patient's case. Affirming the trial court's judgment, the court held that the general question of whether or not the gynecologist was negligent in obtaining the patient's consent has been concisely and simply presented to the jury and that no error had been committed.—*Kruszewski v. Holz*, 290 A.2d 534 (Md. Ct. of App., May 10, 1972).



THE WHITE HOUSE

WASHINGTON

September 29, 1972

PERSONAL

Dear Dr. Ramsey:

At your suggestion, Congressman William Bray has passed along to me the copy of the July issue of *The Journal of the Indiana State Medical Association*. I have noted with pleasure the impressive cover picture, created by Dr. W. P. Loh, which depicts so beautifully the spirit of peace we all so fervently desire. I want to thank you for bringing this magazine to my attention.

With my appreciation and best wishes,

Sincerely,  
Richard Nixon

*Indiana Medical Foundation, Inc.*

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

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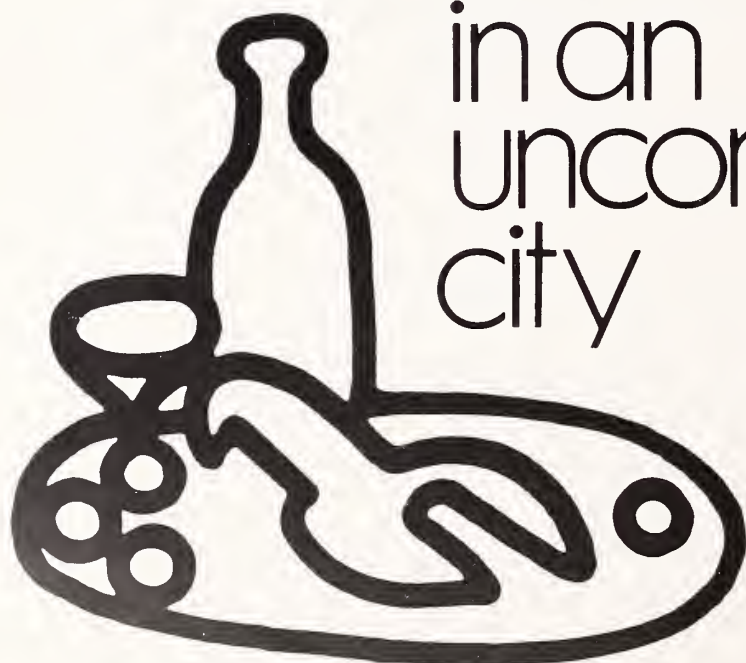
The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

Contributions have been given in memory of the following persons:

Mrs. Ralph V. Everly, Robert S. Smith, Mahlon Miller, M.D., Judge Lloyd Claycomb, Mrs. Mary Black, Ross Griffith, Jr., Guy Spring, Gordon Batman, M.D., Miles Barton, D.D.S., Henry Bibler, M.D., Paul D. Crimm, M.D., G. O. Larson, M.D., Guy Morrison, Mary Rogers, Dale Lentz, Sr., D.D.S., Walter U. Kennedy, M.D., Russell Sage, M.D., Mr. Ralph Hamill, and E. Rogers Smith, M.D.



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# The Cooper Quiz—Answers

The New England Journal of  
Medicine, April 6, 1972

1. False

"Alcoholism and cirrhosis increase host susceptibility to a wide variety of serious and often lethal bacterial infections. Nutritional and mechanical factors are partially responsible; however, other reasons have been identified. Brayton and his associates demonstrated that ethanol caused marked depression of leukocyte migration in the healthy host; a group of cirrhotic patients (not given ethanol) had normal white-cell mobilization. Johnson et al. found that intravenous administration of alcohol to normal volunteers decreased serum bactericidal capacity for gram-negative bacilli.

"The complement system is a known mediator of immunologic functions, some of which are important for host defense. Patients with advanced liver disease have depressed serum complement and elevated ammonia levels; Beeson and Rowley demonstrated that tissue known to have a high concentration of ammonia has an anticomplementary effect. In the cirrhotic patient we found that polymorphonuclear - leukocyte chemotaxis was markedly impaired and that the defect was associated with both a serum inhibitor of chemotaxis and a deficit of known complement components."

(April 6, 1972, pg. 735,  
col. 1, para. 2)

2. True

"In a 40-year-old man with

bone pain, hypophosphatemia, normocalcemia, elevated serum alkaline phosphatase and increased renal phosphate clearance, and radiologic evidence of osteomalacia, acquired vitamin-D-resistant rickets (VDRR) was diagnosed. The patient responded to vitamin D and oral phosphate until a pharyngeal tumor was removed in 1965. After surgery, his serum phosphate rose, and hypercalcemia supervened. Therapy was stopped, but these changes have persisted. He remains free of bone pain, with normal serum phosphate and alkaline phosphatase, but with elevated levels of serum calcium and parathyroid hormone. The temporal relation between tumor removal and apparent cure of VDRR suggests that the tumor was secreting a vitamin D antagonist. The histologic findings suggested a similar cell type in this case and three similar ones. These cases should be referred to as ossifying mesenchymal tumors associated with VDRR."

(April 6, 1972, pg. 740,  
"Abstract")

3. (a)

"The literature on the heroin - withdrawal syndrome of newborn infants contains many references to hyperirritability, frequent yawning and sneezing as part of the symptom complex, but an increased respiratory rate is not specifically mentioned. Yet most of these infants are tachypneic; respiratory rates occasionally rise above 100 per minute. The abstinence - induced hyperpnea is

continuous, and thus different from the occasional bursts of rapid respiration commonly occurring in normal infants during the first few weeks of life.

"Similar findings have been reported in adults with withdrawal symptoms, and have been attributed to an increased sensitivity of the respiratory center to carbon dioxide."

(April 6, 1972, pg. 746,  
col. 1, para. 2)

4. False

"Our findings confirm the presence of a rapid respiration in infants with manifestations of heroin withdrawal. At present, the diagnosis of the syndrome relies largely on unquantifiable observations, such as the pitch of a cry, the degree of irritability, and the coarseness of tremors. An accurate count of the respiration may prove to be a more precise diagnostic adjunct, especially in mild cases. However, an accurate count of the respiration requires patience. The hyperpnea of heroin withdrawal in infants has long been overlooked because the nursery staff is accustomed to occasional brief bursts of rapid respiration in normal newborn infants, and because these addicted infants are rarely at ease; they are constantly squirming and crying and thus difficult to observe.

"The cause of the hyperpnea is unknown, though in adult addicts, it is believed to be attributable to an increased sensitivity of the respiratory center to carbon dioxide. In our patients a metabolic acidosis could



be excluded as the cause of the hyperventilation because there were no significant differences in calculated base excess values between patients and controls.

"Hyperventilation may have some beneficial effects in newborn infants. Though about 50 per cent of infants born to heroin addicts weigh less than 2500 g, and 1/2 of these are premature in terms of gestation (less than 38 weeks), the respiratory - distress syndrome is extraordinarily rare.

"One may conjecture that the normal or elevated blood pH present in these infants affords protection against pulmonary hypoperfusion, so commonly seen in the respiratory - distress syndrome in association with low blood pH. Another potential benefit is a reduced risk from bilirubin encephalopathy, since bilirubin binding capacity of albumin improves with a rising pH.

"Adverse effects of hyperventilation include increased evaporative losses through the respiratory tract and a decrease in ionized serum calcium as a result of the respiratory alkalosis. The latter effect seems to be potentially more dangerous in low-birth-weight infants, who are prone to low serum calcium levels. A possible causative relation between low ionized calcium levels and the myoclonic jerks or seizures occasionally seen in this syndrome requires study."

(April 6, 1972, pgs. 747-748, col. 2, para. 3)

5. True

"Serum albumin is the major protein produced in the liver, comprising as much as 50 per cent of the productive effort at any one moment. The concentration of this protein in the plasma has long been used as a

bellwether of health and disease. Yet it must be remembered that the serum albumin level is only the complex end result of synthesis, degradation and distribution."

(April 6, 1972, pg. 748, col. 1, para. 3)

**The New England Journal of Medicine, April 13, 1972**

6. True

"Bone-marrow transplantation in severe combined immunodeficiency (Swiss - type agammaglobulinemia) from an HL-A identical sibling may reverse a disorder characterized by a progressive downhill course with death, usually by one year of age. Since 1968, when Gatti and his associates reported the first successful bone - marrow transplantation in this disorder, at least 16 other patients have received transplants, most of which have demonstrated engraftment as determined by chromosomal chimerism. Three of these patients are surviving for over three years. Although the cellular immunodeficiency permits successful engraftment, varying degrees of graft-versus-host (GVH) reactions have developed in all these patients, presumably because of minor histocompatibility antigen differences. These GVH reactions are nonfatal and self-limited; in contrast, the GVH reaction has proved to be fatal in all cases when HL-A differences exist."

(April 13, 1972, pg. 797, col. 1, para. 2)

7. False

"The Marfan syndrome is a heritable generalized disorder of connective tissue in which life expectancy is greatly reduced. Clinically, the most prominent abnormalities are found in the skeleton, the eye

and the cardiovascular system. The typical clinical picture is easily recognized in the patient with long, thin extremities, arachnodactyly, hyperextensible joints, chest deformity, dislocated lenses and evidence of aortic dilatation.

"It is the cardiovascular manifestations of the syndrome that lead to the poor prognosis. Weakness of the aortic media, with loss of elastic fibers, results in progressive dilatation of the aorta. The weakened wall is subject to dissection and rupture. Dilatation of the aortic ring or involvement of the valve itself may lead to aortic regurgitation, and narrowing of the coronary ostia may produce coronary insufficiency. The mitral valve may also be involved, and any combination of these cardiac lesions may cause the reduced life expectancy in this syndrome."

(April 13, 1972, pg. 804, col. 1, para. 2)

8. (c)

"Since reproductive fitness is only slightly reduced in the disorder the great majority of cases with the Marfan syndrome will be familial. McKusick has estimated that as few as 15 per cent of cases are the result of new mutation. It is in affected families that the best demonstration of the full spectrum of involvement would be expected, for a mildly affected sporadic patient is less likely to be found than an equally affected member of an affected family. In this study extensive evaluation of the relatives in typical cases led to the discovery of numerous mildly, but definitely affected members. Even here, however, the index cases were usually found because some severe problem



prompted medical evaluation. In large affected families this biased view was partially corrected by family follow-up observation, but this, of course, was ineffective in the sporadic cases. It is difficult to estimate the exact proportion of sporadic cases in the group under evaluation, but at least 23 of the 257 patients were definitely without positive family history and were used in a study of the effects of parental age on the occurrence of new mutations."

(April 13, 1972, pg. 806,  
col. 1, para. 1)

#### 9. False

"Although it is too early to draw conclusions about increased survival for patients with the Marfan syndrome treated with propranolol or reserpine it seems likely that this form of therapy may well prolong survival in this group as similar medical therapy has in other forms of aortic dissection. Propranolol should be considered in all patients with evidence of aortic regurgitation who have no history of a disorder such as asthma or congestive heart failure that might be exacerbated by the medication. In these cases reserpine should probably be substituted."

(April 13, 1972, pg. 808,  
col. 1, para. 1)

EDITOR'S NOTE: Cardiovascular complications are the prime cause of death in Marfan's syndrome, and chief among these is progressive involvement of the aortic media. Surgery, despite a high mortality rate, does have some offers of hope.

#### 10. True

"EACA was first synthesized in 1899. It was shown to have anti-plasmin activity in 1953,

and was later shown to inhibit plasminogen activation markedly. These properties have led to its widespread use clinically as an antifibrinolytic agent in situations in which bleeding secondary to fibrinolytic activity presents a major clinical problem. The drug also affects immunologic reactivity. It has been noted to delay graft rejection, to inhibit immediate and delayed hypersensitivity and to inhibit the complement system. The latter effect is reported to be due to its ability to inhibit Cl.

"The possible benefit of EACA to patients with angioneurotic edema was first suggested in 1966 in one case. Since that time several case reports have appeared suggesting that this drug or an analogue, tranexamic acid, is of value in some cases. The extreme variability in the frequency of attacks and in the clinical manifestations of the disease made it essential to perform a double-blind clinical trial.

"EACA prevented attacks of angioneurotic edema in four of five patients with this disease studied over a two-year period. In these patients the 'tingling' feeling of a prodrome was occasionally noted, but there were no typical episodes of swelling. In the remaining case it was believed that the drug was nevertheless useful in modifying or preventing attacks."

(April 13, 1972, pg. 811,  
col. 1, para. 3)

#### 11. False

"In a double-blind crossover study of marketed drugs given by the oral route to relieve pain, aspirin (650 mg) was superior to all agents tested. Mefenamic acid (250 mg), pentazocine (50 mg), ac-

etaminophen (650 mg), phenacetin (650 mg) and codeine (65 mg) also showed a significant advantage over a placebo. Propoxyphene (65 mg), ethoheptazine (75 mg) and promazine (25 mg) gave no significant evidence of therapeutic activity; and each of these agents was significantly inferior to aspirin in analgesic effect. Pentazocine (50 mg) produced sufficient gastrointestinal and central-nervous-system side effects to make this agent of dubious value for ambulatory patients. All other drugs tested in this single dose study did not produce significantly greater side effects than a placebo."

(April 13, 1972, pg. 813,  
"Abstract")

### The New England Journal of Medicine, April 20, 1972

#### 12. False

"The degree of pulmonary emphysema is far greater among cigarette smokers than among nonsmokers, and generally increases with advancing age. This is in agreement with findings in prospective epidemiologic studies that death rates from emphysema are far higher among cigarette smokers than among nonsmokers.

"The results of this study are also consistent with findings in three experiments in which emphysema was produced in dogs by having the animals inhale cigarette smoke over a long time.

"On the basis of all this evidence, we believe that cigarette smoking leads to pulmonary emphysema, and that among men who continue to smoke cigarettes, the degree of disease increases with age."

(April 20, 1972, pg. 857,  
col. 2, para. 4)



13. False

"Reduction of serum bile salt concentrations and relief of pruritus in intrahepatic biliary atresia and benign recurrent cholestasis occurred after four to seven days of PB therapy. The patient with intrahepatic biliary atresia has subsequently required continuous long-term PB therapy for control of pruritus and reduction of jaundice. Although control of pruritus and jaundice in intrahepatic atresia appears to require continuous PB therapy, short-term PB treatment appears to be successful in ameliorating attacks of benign recurrent cholestasis. Whether prolonged PB treatment on a maintenance basis could influence the frequency of relapses in benign recurrent cholestasis or the ultimate outcome in intrahepatic biliary atresia remains to be determined in future studies."

(April 20, 1972, pg. 860,  
col. 2, para. 3)

14. True

"This report describes the relation between arterial pressure and plasma volume in hypertensive patients treated with adrenergic blocking drugs alone or in combination with a thiazide diuretic. The results show a highly significant, quantitative relation between blood pressure and blood volume during treatment with antihypertensive drugs and suggest that good blood-pressure control is synonymous with maintenance of a reduced blood volume."

(April 20, 1972, pg. 861,  
col. 2, para. 3)

15. True

"Systematic screening of 13,300 consecutively registered Danish voluntary blood donors revealed 24 donors with persistent Au-antigenemia. None of

these had any clinical signs of disease. Liver biopsies were performed on all the Au-antigenemic donors. In only one of the 24 biopsies was cirrhosis demonstrated. None of the remaining 23 biopsies, of which six showed a completely normal histologic picture, exhibited the changes seen in viral hepatitis.

"Before detection of the antigenemia 10 of the Au-antigenemic donors had given blood to 22 recipients. A retrospective study gave no evidence of past or present acute hepatitis in any of these recipients. No Au-antigen or Au-antibody was found in any of the surviving recipients.

"The apparent absence of post-transfusion hepatitis in the recipients may be related to the absence of acute and chronic hepatitis in the blood donors."

(April 20, 1972, pg. 867,  
"Abstract")

**The New England Journal of  
Medicine, April 27, 1972**

16. True

"To evaluate the diagnostic potential of various readily available clinical procedures, 100 selected patients suspected of having coronary-artery disease were studied by both coronary cinearteriography and a selected pattern of standard tests and observations. Sixty-two patients had angiographic evidence of obstructive coronary atherosclerosis; 38 did not. Although individual clinical abnormalities were often unreliable indicators of coronary-artery disease, their diagnostic accuracy increased markedly when they were used in combination with one another to form a clinical index. This index, determined through multiple discriminant analysis, accurately diagnosed 94 of the

100 cases. The index was then applied to a prospective series of 100 similarly selected patients. Ninety-two were correctly diagnosed. In both the original study group and the prospective series, index values less than 100 were rarely associated with coronary atherosclerosis. Conversely, patients with indexes above 100 almost always had obstructive coronary-artery disease."

(April 27, 1972, pg. 901,  
"Abstract")

EDITOR'S NOTE: We apologize for this poorly worded question but we felt that we all need to be aware of any testing devices that may become clinically significant in this field. We are sorry that the authors do not even suggest a name for their index.

17. True

"A group of patients with systemic lupus erythematosus had in their serums precipitating antibodies to a soluble nuclear ribonucleoprotein antigen, a low frequency of complement-fixing antibodies to single-stranded DNA, and a paucity of serious renal disease. As in other reported series, a positive relation was found between the presence of complement-fixing antibodies to single-stranded DNA and the frequency of nephritis. In their nonrenal clinical manifestations the patients with antibodies to the RNAprotein antigen resemble others with systemic lupus erythematosus, but as might be expected from the low prevalence of nephritis, their prognosis thus far appears favorable."

(April 27, 1972, pg. 908,  
"Abstract")



18. False  
“A longitudinal seven - year study of 50 patients with chronic airway obstruction, whose cardiovascular function had been evaluated by cardiac catheterization when their condition was stable, showed that their survival was inversely related to pulmonary vascular resistance.

“Fourteen patients with high vascular resistances showed two different patterns of cardiovascular abnormality. Nine had relatively normal blood gases, low cardiac outputs, and near normal resting pulmonary-artery pressures; they had an emphysematous type of lung disease. The five with more severe blood gas abnormalities who had a more bronchitic type of disease, had well maintained cardiac outputs and more severe pulmonary hypertension. They more regularly presented the classic clinical and electrocardiographic features of cor pulmonale. Left ventricular dysfunction appeared to be an important determinant of pulmonary hypertension in only one patient.”

(April 27, 1972, pg. 912,  
“Abstract”)

EDITOR’S NOTE: We do not usually quote so many “abstracts.” In these papers it was

the only place we could get the real “meat” of the article without long, long quotations.

19. (1) = (a) (2) = (b)  
“Euthyroid persons produce approximately 80 micrograms thyroxine (T<sub>4</sub>) and 50 micrograms of tri-iodothyronine (T<sub>3</sub>) daily. Although values for the rates of secretion or production of the individual thyroid hormones would be most desirable for evaluating a patient’s thyroid status, the necessary kinetic studies are seldom clinically feasible, and reliance is therefore placed upon other tests and procedures. These include measurements of the concentration of the thyroid hormones in plasma, the hormone-binding capacity of the plasma proteins, the avidity with which the thyroid gland accumulates iodine, and the concentration of circulating thyroid - stimulating hormone (TSH).”  
(April 27, 1972, pg. 924,  
col. 1, para. 1)

20. (a)  
“Scintiscans permitting visualization of the distribution of glandular radioiodine are often of considerable clinical value. The scan readily distinguishes between the diffuse glandular hyperactivity in Grave’s disease and the patchy pattern of ac-

tivity in toxic nodular goiter, and permits functional classification of nodules in nontoxic goiters as ‘hot’, ‘warm’, and ‘cold,’ and in association with thyroid suppression regimens, the autonomous or TSH-dependent nature of hot and warm nodules may be determined. Scans also provide useful information regarding the size, shape and position of the gland and facilitate identification and localization of functioning thyroid tissue in ectopic or metastatic sites. They are helpful in estimating the degree of glandular involvement in subacute thyroiditis, and in assessing recovery from this disorder. Refinements in scanning procedures include the use of <sup>125</sup>I to improve resolution, and of <sup>99m</sup>Tc- pertechnetate to permit earlier visualization with less radiation exposure; x-ray fluorescence methods under development, which involve no administration of isotope to the patient, may permit estimating glandular iodine content and differentiating ‘cold’ nodules, which are primarily cellular and contain little iodine, from those containing large amounts of colloid.”

(April 27, 1972, pg. 926,  
col. 1, para. 3)

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# Deaths

## Robert E. Bakemeier, M.D.

Dr. Robert E. Bakemeier, 43, Indianapolis surgeon, died September 28 in Community Hospital.

A graduate of the Indiana University School of Medicine, Doctor Bakemeier interned at Detroit Receiving Hospital and was a resident at Marion County General Hospital from 1958 through 1962. He was on the staffs of Hendricks County, Community, St. Francis and the Marion County General Hospital.

He was an Air Force flight surgeon stationed at Spokane, Wash., in 1956-1957 and was commander of the Air Force Reserve Hospital at Wright-Patterson Air Force Base, Dayton, in 1966.

Dr. Bakemeier was a fellow of the American College of Surgeons and was a member of the Marion County Medical Society.

## Charles E. Gorham, II, M.D.

Dr. Charles E. Gorham, II, New Paris, died September 13 in a one-car accident north of New Paris. He was 37.

A 1961 graduate of the Indiana University School of Medicine, he interned at Memorial Hospital, South Bend, and had maintained offices at New Paris and Milford for the practice of medicine since completion of his internship.

He was on the staff of the Goshen Hospital and was a member of the Elkhart County Medical Society.

## John W. Kimble, M.D.

Dr. John W. Kimble, 40, who had been a general practitioner in Mooresville and was on the Methodist Hospital emergency room staff, died September 8 at Methodist after a three-day illness.

A deputy coroner for Morgan County, Dr. Kimble was a graduate of the Ohio State University Medical School and

interned at White Cross Hospital, Columbus, Ohio. He served a surgical residency at Riverside Methodist Hospital, also in Columbus.

He was a member of the Marion County Medical Society.

## Ames R. Templeton, M.D.

Dr. Ames R. Templeton, 58, an anesthesiologist at St. Joseph Hospital, Mishawaka, for nearly a quarter of a century, died October 1 in St. Mary's Hospital, Rochester, Minn.

Dr. Templeton was a graduate of the Indiana University Medical School and interned at South Bend Memorial Hospital in 1939-40. He served as an anesthesiologist resident in Hines Veterans Hospital, Chicago, from immediately after World War II until 1948, when he returned to Mishawaka.

He was a member of the American Society of Anesthesiology and the St. Joseph County Medical Society.

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# County, District News

## Ninth District

Dr. Don W. Boyer, Lebanon, president of the Ninth District Medical Society, presided at the annual meeting which was held at the Ulen Country Club on June 28, 1972.

Dr. Barton Bridge and Mr. Gary Miller discussed some Blue Shield problems and the proposed merger of Blue Cross and Blue Shield. Dr. Wemple Dodds, Crawfordsville, one of the founders of Blue Shield told of the origin of the plan.

It was announced that the Fountain-Warren County society would be host for the 1973 meeting, with time, place and officers to be decided later.

## Clark

The administrator of Clark County Memorial Hospital, the director of the Mental Health and Guidance Center of Southeastern Indiana, and the coordinator of the alcoholic treatment program at the health and guidance center were guests at the July meeting of the Clark County Medical Society. Twenty-seven members were present and participated in the general discussion that followed each speaker's presentation.

## Marshall

Dr. R. Charles Eades, South Bend, was the speaker at the June 7 meeting of the Marshall County Medical Society.

During the business meeting that followed Dr. Jose DeJesus was named delegate to the ISMA with Dr. James S. Robertson as alternate.

## Orange

At a recent meeting of the Orange County Medical Society Dr. Charles McCalla, Paoli, was re-elected president and Dr. P. T. Hodgins, Orleans, was re-elected secretary.

## Porter

A resolution recommending the establishment of an appropriately qualified psychiatric unit within the Porter Memorial Hospital was endorsed at the September meeting of the Porter County Medical Society.

Dr. Uldarico Blando was named by President John Forchetti to be chairman of a committee to revise and update the society's bylaws. Serving with him will be Drs. William C. Robertson, Tom Dittmer, Robert Lee, Thomas Covey, Wil-

liam McBride, Alfred Kobak and Frank Sturdevant.

Drs. Lyle Havens, George Wolverton, Robert Robertson and William Voskuhl were named to a committee to meet with coaches and superintendents of the major school systems in the county to work out a system for handling physical exams for athletes.

A joint meeting with the Floyd County group was held September 8 at New Albany. ISMA president Peter Petrich and president-elect James Gosman spoke and answered questions, as did Dr. John M. Paris.

## Dearborn-Ohio

Twelve persons were present for the Dearborn-Ohio County Medical Society meeting on September 7.

Mr. Herbert Dixon, Blue Shield, gave a report and answered many questions put forth by members.

## Hendricks

Newly elected officers of the Hendricks County Medical Society are: President, Dr. Eric D. Clark, and secretary-treasurer, Dr. David M. Hadley, both of Plainfield.

## About Our Cover

Our cover is intended to call attention to the article about Dr. Alfred J. Ralph, Brown County physician in the latter part of the Nineteenth Century and the first part of the Twentieth, which begins on page 1156.

Reproduced on the cover are two receipts for fees paid for medical education, a view inside Dr. Ralph's office, the office at New Bellsville, and the doctor as a young man.

The office has recently been designated a State Historical Landmark and will be moved to Nashville in the near future.



# Association News

## EXECUTIVE COMMITTEE

September 27, 1972

The Executive Committee convened at 10:00 a.m. Wednesday, September 27, 1972 in the Headquarters Building.

Roll call showed the following present: Donald M. Kerr, M.D. Chairman, Peter R. Petrich, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, M.D., Wilbert McIntosh, M.D., and James A. Waggener.

MINUTES OF THE MEETING held on August 5 1972, were approved on motion of Dr. Petrich and seconded by Dr. McIntosh.

MINUTES OF TELEPHONE CONFERENCE held on September 14th were approved on motion of Dr. Petrich and a second by Dr. McIntosh.

### Membership Report

Reviewed and taken as a matter of information.

Number of members as of

December 31, 1971 .....4,557

1972 members as of

August 23, 1972:

Dues paying members .....4,007

Residents and interns ..... 67

Senior ..... 375

Board Remitted ..... 59

Honorary ..... 3

Military ..... 32

Total 1972 members as of

August 23, 1972\* .....4,544

Total 1971 members as of

July 31, 1971 .....4,489

Number of AMA members as of

July 31, 1971 .....4,236

Number of AMA members as of

August 23, 1972 .....4,196

Dues paying .....3,730

Exempt but active ..... 466

4,196

Number who paid state dues not

AMA dues as of August 23, 1972 .345

\*Includes 3 honorary members.

Number of AMA members as a result of AMA mailing and Dr. Petrich—12

### Headquarters Office

#### MEMBERSHIP RECOGNITION —

The secretary presented a decal for doctors' use on doors or waiting room windows to indicate they are members of the Indiana State Medical Association, with the purchase price of 4,000 being approximately \$600.

On motion of Dr. McIntosh, seconded by Dr. Petrich, the secretary is authorized to purchase 4,000 of the decals.

REQUEST FOR REFUND OF PARTIAL DUES — The matter of a refund of partial dues to Dr. Vincente P. Delumpa was reviewed and, inasmuch as Dr. Delumpa became a member after the first of July, the secretary is authorized to refund one-half of his dues.

PROPOSAL FROM PEINE ENGINEERING CO. — The secretary presented a report from the Hartford Steam Boiler Inspection and Insurance Company pointing out some repairs that should be made on the boiler and a proposal of Peine Engineering Company submitting a quotation for the work at a cost of \$1,351. On motion of Dr. McIntosh, and a second by Dr. Petrich, the proposal of Peine Engineering Company was approved.

### Treasurer's Report

The Treasurer reported on the cash report and income projection; the report of the dues distribution, together with rundown on the refund due on the CHAMPUS contract for overpayment of administrative costs. The secretary is instructed to have the George S. Olive Company review the CHAMPUS matter before payment is made.

### Convention Matters

SHUTTLE BUS — The secretary reported that Indiana University Alumni Association had offered to provide a shuttle bus — using the big red double decker London bus and their offer was accepted on motion of Dr. McIntosh and seconded by Dr. Petrich and Dr. Petrich is to write a letter of appreciation to the Indiana Alumni group.

BOB BRAUN SHOW — The secretary reported that the Bob Braun Show —50 50 Club, had offered to put on their telecast from the Convention Center during the ISMA Convention providing we would furnish a room. The Convention Center quoted a price of \$600 rental for the Ballroom. On motion of Dr. McIntosh and a second by Dr. Petrich, the secretary is instructed to negotiate with the Convention Center and is permitted to pay as much as \$300 rental fee.

SALE OF EXHIBIT SPACE — The matter of sale of exhibit space for the annual meeting was reported showing 74 spaces sold to 63 companies with an income of \$19,600 and the report was taken as a matter of information.

REQUEST FROM DAIRY COUNCIL — The request from the Dairy Council to be permitted to exhibit at the Indiana State Medical Association meeting as a scientific exhibit was reviewed and on motion of Dr. Dukes, seconded by Dr. Petrich, the decision on this matter is to be left to the Chairman of the Scientific Committee.

REQUEST of PATHLABS, INC. — The request of Dr. David Smith to have an exhibit for Pathlabs, Inc., was reviewed and on motion of Dr. Gosman, seconded by Dr. Petrich, acceptance of this exhibit as a commercial exhibit was approved.

### Organization Matters

CONNERSVILLE MATTER — The secretary reported he had been contacted by the Fayette-Franklin County Society concerning the Connersville matter which had previously been referred to the Commission on Medical Education and Licensure. The report was accepted as a matter of information.

LICENSURE OF FOREIGN GRADUATES — The section dealing with the licensure of graduates of foreign medical schools contained in the proposed Medical Practice Act, as requested by the Commission on Medical Education and Licensure was taken as a matter of information.

REPORT OF DR. BRYAN — A report from Dr. Bryan on his attendance at a meeting called by Mr. Wilkie on August 29th was reviewed for the information of the committee.

INTERCEPT-A-CHARGE, INC. — A proposal by Intercept-A-Charge, Inc., was reviewed by the president and on motion of Dr. McIntosh and seconded by Dr. Gosman this matter is to be referred to the Commission on Medical Economics and Insurance.

Dr. Gosman moved that this be recommended to the Commission on Medical Economics and Insurance to be made as an offering to the membership of ISMA.

The motion was seconded by Dr. Petrich and carried.

GERALD B. LAMBERT AWARDS— A letter concerning the Gerald B. Lambert awards was read and taken as a matter of information.

REPORT FROM THE AMA — A report from the AMA concerning medical student membership in the AMA was reviewed and on motion of Dr. Petrich, seconded by Dr. Gosman, Indiana Chap-



ter SAMA members are to be encouraged to attend but the association will not defray any of their expenses.

**REPORT OF DR. BECKER** — Dr. Becker's report on his attendance at the Communications Clinic was received and ordered referred to the Commission on Public Information.

**REPORT OF DR. HAWKINS** — A report was received from Dr. R. D. Hawkins concerning his attendance at a meeting held by the Insurance Commissioner on September 13th for a discussion of drafting HMO legislation.

On motion of Dr. Gosman and taken by consent, the report was adopted and ordered referred to the Commission on Legislation.

**REPORT FROM DR. JOE YOUNG** — A report from Dr. Joe Young of Greenwood and Dr. Lyman Eaton of Indianapolis expressing their feelings that the pamphlet on "Medicare Misconceptions" was one of the finest publications put out by ISMA was read. They further recommended that it be published in every newspaper in Indiana and the secretary is instructed to refer this to the Commission on Public Information.

**LETTER FROM AMA ON CHARLOTTE KERR, M.D.** — A letter from the AMA concerning the receipt of a recommendation on Charlotte Herman Kerr, M.D., for appointment to the Committee on Medical Aspects of Sports is to be discussed with the trustee of the district concerning this recommendation.

**FACT SHEET FROM HEW ON MEDICARE** — The secretary reviewed a current Medicare Information Fact Sheet from the Department of HEW setting forth the uniform method for handling suspension of Medicare payment. This was taken as a matter of information.

**LETTER FROM INDIANA PUBLIC HEALTH ASSN.** — A letter from the Indiana Public Health Association requesting a contribution for the Legislative Reception and Buffet was read together with the Minutes of the Commission on Legislation recommending a contribution of \$100. On motion of Dr. Petrich, seconded by Dr. Gosman, a \$100 contribution was approved.

**LETTER FROM THE BOARD OF HEALTH** — A letter from the Board of Health concerning the proposed Seminar on Hospital Services in Rural Indiana was reviewed and, on motion of Dr. Dukes, a second by Dr. McIntosh, the

Editor of the *Journal* is to be requested to advertise this in the *Journal*.

**LETTER FROM DR. LELAND G. BROWN** — A letter from Dr. Leland G. Brown proposing legislation concerning interference with Health Care Facilities was reviewed and on motion of Dr. Dukes, seconded by Dr. McIntosh, this is to be referred to the Commission on Legislation.

**LETTER FROM AMA ON PEER REVIEW** — The secretary reviewed a letter from the AMA in answer to his inquiry concerning Peer Review organizations setting fees for providers and this was taken as a matter of information with the membership of the Executive Committee requesting that this be duplicated and sent to each of them as well as to being referred to the Commission on Medical Economics and Insurance.

**LETTER FROM HEW ON EMCRO** — A letter from the Department of HEW inviting the Indiana State Medical Association to apply for a grant for developing an experimental Peer Review Organization was reviewed. On motion of Dr. Dukes, seconded by Dr. McIntosh, this is to be filed.

**MINUTES OF PUBLIC HEALTH TASK FORCE MEETING** — The minutes of the Public Health Task Force meeting on August 21st and September 11th were distributed to members of the committee for their information.

**BOARD OF TRUSTEES DINNER** — Dr. Dukes moved that the trustees and alternate trustees elect be extended an invitation to attend the annual Board of Trustees formal dinner on Saturday night, October 14th. The motion was seconded by Dr. McIntosh and carried.

### **Insurance Matters**

**HORACE MANN LIFE INSURANCE—GRANT COUNTY REPLY** — A letter from the Horace Mann Life Insurance Company questioning services rendered to two of their policy holders, which had been referred to the Grant County Medical Society, who returned it to ISMA stating they were referring it back to us, was reviewed and by consent this is to be referred to the Claims Review Committee of ISMA.

**JOHN HANCOCK LIFE INSURANCE COMPANY LETTER** — A letter from John Hancock Life Insurance Company concerning a charge made by an Indiana physician was reviewed and by consent was referred to the Insurance

Claim Review Committee.

**CORRESPONDENCE BETWEEN DR. BIBLER AND BLUE SHIELD** — An exchange of correspondence between Blue Shield and Dr. Lester D. Bibler was read and this is to be referred to the Blue Shield Board member of Marion County.

**CORRESPONDENCE BETWEEN BLUE SHIELD AND PHYSICIAN** — Correspondence between Blue Shield and another Indiana physician concerning payment of his fees was reviewed and the secretary is instructed to write the physician making suggestions on how to handle these matters in the future and copies of this is to be forwarded to the representative Blue Shield Board member from the physician's district.

**LETTER FROM JOE E. PEARCE** — A complaint from Joe E. Pearce concerning the activities of Blue Shield and the payment for services rendered his daughter was reviewed and by motion of Dr. Petrich, a second by Dr. Gosman, this file is to be referred to the Marion County Medical Society and also copies sent to the Blue Shield Board member in the respective district.

**CORRESPONDENCE BETWEEN BLUE SHIELD AND DR. WATSON** — Correspondence between Blue Shield and Dr. Leo Watson was reviewed and this was ordered sent to the Blue Shield Board member of his district.

**LETTER FROM AMA TO BLUE CROSS** — A copy of a letter addressed to Blue Cross by the AMA concerning the selection of Indiana by HEW as a test project for the use of Uniform Medical Procedure Terminology and Code System was reviewed for the information of the committee.

**MINUTES OF EXECUTIVE COMMITTEE OF BLUE CROSS** — Minutes of the meeting of Blue Cross held August 17th were reviewed for the information of the committee.

**DR. WOOD — VISIT OF AMA TRUSTEES** — Dr. Don Wood, AMA trustee, appeared before the Committee and stated that several members of the Board of Trustees of the AMA would be in Indianapolis on October 17th for the purpose of reviewing the Medi-Tech Program and asked if it would be permissible for him to attempt to get these men to stay over for the President's Dinner Dance. On motion of Dr. Hoyt, seconded by Dr. Petrich, Dr. Wood is authorized to invite them for this affair.



## Legal Matters

**MEDICAID AND MEDICARE REGULATION** — Dr. Petrich raised the question concerning the establishment of fees under the Medicaid and Medicare Program stating there is some feeling that the regulation was unconstitutional and suggested we have our attorney check out the constitutionality of these regulations. The recommendation was approved on motion of Dr. Petrich and seconded by Dr. Gosman.

## New Business

**TWO RESOLUTIONS FROM EXECUTIVE COMMITTEE** — Dr. Petrich then presented two resolutions for presentation to the House of Delegates from the Executive Committee — one dealing with the cost of hospital care and the other dealing with utilization and peer review organizations. Introduction of these resolutions was approved on motion of Dr. Petrich and Dr. Gosman.

**TELEPHONE SYSTEM** — The secretary pointed out that he had reviewed some information from Alabama where they had installed an On-Line Claims Filing Process for the membership and he had discussed this with the telephone company and it could be done in Indiana. By consent, he was authorized to look further into this system.

**REQUEST FOR REFUND** — A request from Medical Plastics, Laboratories, Inc., for a refund of their deposit for an exhibit at the annual convention was approved by consent.

## Future Meetings

A notice of the meeting being called by the Nurses Association for the purpose of developing Emergency Room Nursing Standards was reviewed for the information of the committee.

A letter from the AMA calling attention to a pilot program to be held in Chicago October 11-13 on Office Practice Management was read and, by consent, it was agreed that Doctor Neumann or a member of his Commission should attend this meeting to monitor the program.

A notice from the AMA concerning the Third National Conference of State Medical Association Representatives on Continuing Medical Education to be held in Chicago October 24-26 was read and, by consent, it was agreed to send Dr. Bryan or a person designated by him.

A letter was read from the Illinois State Medical Society concerning a Leadership Conference which they propose to have in Chicago on October 29th and, by consent, Dr. Lowell Steen or Dr. Vincent Santare is to be requested to attend, if possible.

A notice of the meeting of the Association of American Medical Colleges in

Miami November 2-6 was read and no representative is to be sent.

A notice was read of the Conference on the Physician and Environmental Quality Control to be held in Detroit on November 9-10. On motion of Dr. Hoyt, seconded by Dr. Dukes, no one will be sent.

A notice was read of a Seminar on Foundations for Medical Care to be held in Denver, Colorado November 12-15 and, by consent, no representative will be sent.

Announcement of a Course on Emergency Care conducted by the American Academy of Orthopaedic Surgeons to be held in St. Louis November 26-29 was reviewed and, by consent, no representative will be sent.

A letter from the Student AMA regarding students attending the Clinical meeting in November was reviewed by the committee.

The secretary announced that, in correspondence received, Dr. Lowell Steen had been named to the Reference Committee on Miscellaneous Business at the Cincinnati Meeting.

There being no further business, the committee adjourned to meet again at 9:00 a.m. Saturday, October 14, 1972, at the Indianapolis Convention Center.

Statement of ownership, management and circulation (Act of August 12, 1970; Section 3685, Title 39, United States Code)

1. Title of Publication: THE JOURNAL of the Indiana State Medical Association.

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7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.) Name: Non-Profit Corporation — No Stockholders.

8. Known bondholders, mortgagees, and other security holders owning or holding 1

percent or more of total amount of bonds, mortgages or other securities: None.

9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual): 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U. S. C. 3626. (Signature and title of editor, publisher, business manager, or owner):

10. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual): The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes: Have not changed during preceding 12 months.

11. Extent and nature of circulation.

A. Total no. copies printed (net press run): Average no. copies each issue during preceding 12 months: 4,780. Actual number of copies of single issue published nearest to filing date: 4,725.

B. Paid circulation — 1. Sales through dealers and carriers, street vendors and counter sales: Average no. copies each issue during preceding 12 months: none. Actual number of copies of single issue published nearest to filing date: none. 2. Mail subscrip-

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C. Total paid circulation: Average no. copies each issue during preceding 12 months: 4,510. Actual number of copies of single issue published nearest to filing date: 4,475.

D. Free distribution by mail, carrier or other means: 1. Samples, complimentary, and other free copies: Average no. copies each issue during preceding 12 months: 220. Actual number of copies of single issue published nearest to filing date: 220. 2. Copies distributed to news agents, but not sold: Average no. copies each issue during preceding 12 months: none. Actual number of copies of single issue published nearest to filing date: none.

E. Total distribution (Sum of C and D): Average no. copies each issue during preceding 12 months: 4,730. Actual number of copies of single issue published nearest to filing date: 4,695.

F. Office use, left-over, unaccounted, spoiled after printing: Average no. copies each issue during preceding 12 months: 50. Actual number of copies of single issue published nearest to filing date: 30.

G. Total (Sum of E & F—should equal net press run shown in A): Average no. copies each issue during preceding 12 months: 4,780. Actual number of copies of single issue published nearest to filing date: 4,725.

I certify that the statements made by me above are correct and complete.

James A. Waggener, Business Manager



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Continued

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

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**DEADLINE:** Fifth day of month PRECEDING month of issue.



Continued

MEDICAL OFFICER (OCCUPATIONAL MEDICINE) needed at U. S. Naval Installation, Crane, Indiana. Share responsibility with Military Physician for occupational medicine program for 5500 Civilian employees and 75 military. Dispensary staffed with three registered nurses, one nursing assistant, several hospital carpenters and clerical personnel. Located in a scenic area 30 miles south of Bloomington, 75 miles southwest of Indianapolis. Installation has 800-acre lake on its 64,000 acres with good fishing and boating. Rental quarters on Depot and military store privileges. Elementary and secondary schools nearby; Indiana University within driving distance. **Equal Opportunity Employment.** Salary, \$23,737 per annum plus approximately \$3,038 per annum for "on-call" service.

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GENERAL PRACTITIONER—a join established group of 5 G.P.'s and 2 surgeons in a modern clinic building adjacent to a community hospital, located in an industrial growing city of 50,000. Salary \$30,000 plus bonus, free malpractice insurance, post graduate study time, and other benefits; partnership after 1 year.

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"GENERAL PRACTICE—Four man medical corporation wants fifth man with initiative to share unlimited general practice located in Northeast Indiana in the middle of 100 lakes. One hour to either South Bend or Fort Wayne. Two hours to Chicago or Detroit. Share interest in Turbo-Aztec. Share unlimited medical challenge with unlimited income. Reap tax rewards of medical corporation with more than ample income left over. In this group you are limited only by your own initiative. Four weeks vacation plus two weeks post graduate training paid by the corporation yearly. Other corporation benefits too numerous to mention. Family Physicians, Inc., P. O. Box 217, Hawes, Indiana, 46746, 219-562-2101."

EMERGENCY CENTER PHYSICIANS, full time, for Lake County Memorial Hospitals, Willoughby and Painesville, Ohio. \$25,000 basic salary, plus opportunity for additional income. Liberal fringe benefits, including professional liability insurance. Must have Ohio license. Contact W. E. Fletcher, M.D., 89 E. High Street, Painesville, Ohio 44077.

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December 1972  
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# It's a lot of cars for the money.

It has rack-and-pinion steering like the racing Ferrari. And a luxurious interior like the Mercedes-Benz 280SE.

It has independent front suspension like the Aston Martin. And the same amount of trunk space as the Lincoln Continental Mark IV.

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**Special Petrolatum Base**  
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Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate, 5000 units;  
zinc bacitracin, 400 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg.  
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In tubes of 1 oz. and ½ oz. for topical use only.

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*Precaution:* As with other antibiotic preparations, prolonged use may  
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neomycin. The possibility of such a reaction should be borne in mind.

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perforated. This product is contraindicated in those individuals who  
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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Indexed in Hospital Literature Index.



# Should old depressives be forgot?

geriatric depressive. Unable to concentrate he tends to take little interest in the affairs around him. His reactions are slow and delayed. He speaks very little. When he does, it's mostly to complain of his insomnia, fatigue, or constipation.

One way of relieving depression in the geriatric patient is with Tofranil.

Please read the prescribing information for details of usage (lower dosages are recommended for elderly patients and adolescents), precautions, warnings, contraindications, adverse experiences, and dosage recommendations. It is summarized below.

## Tofranil® Geigy imipramine hydrochloride USP



### imipramine hydrochloride USP

**Indications:** The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or convulsive seizures may occur. Potentiation of these effects can be serious or even fatal. An interval of at least 14 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be instituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be fully observed. The drug is also contraindicated during the acute recovery period after myocardial infarction, (b) in patients with known hypersensitivity to the drug. Cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformations associated with the use of this drug, but a causal relationship has not been confirmed. Extreme caution should be used when this drug is given to:

patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia; patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;

thyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;

patients with a history of seizure disorder because the drug has been shown to lower the seizure threshold; patients receiving guanethidine or similar agents as imipramine may block the pharmacologic effects of these drugs.

**Usage in Children:** Pending evaluation of results from clinical trials in children, the drug is not recommended for use in patients under twelve years of age, since the drug may impair the mental and/or

physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

**Precautions:** Because of the possibility of suicide in seriously depressed patients, careful supervision during the early phase of treatment is necessary and hospitalization may be required. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential.

**Adverse Reactions:** *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias

of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

**Withdrawal Symptoms:** Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**How Supplied:** Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration. (B)98-146-850-H (7/71)

**For complete details, including dosage, please refer to the full prescribing information.**

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TO 8575





## When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

### **1.2 to 8 grams/day IV dosage range:**

Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections.

In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

### **Effective gram-positive antibiotic:**

Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone





infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be

administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin<sup>®</sup>

Sterile Solution (300 mg per ml)  
(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.







Sterile Solution (300 mg. per ml.)

# Lincocin<sup>®</sup>

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections.

Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:

Lincomycin hydrochloride monohydrate equivalent to lincomycin base

250 mg Pediatric Capsule . . . . . 250 mg  
500 mg Capsule . . . . . 500 mg  
\*Sterile Solution per 1 ml . . . . . 300 mg  
Syrup per 5 ml . . . . . 250 mg

\*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

**CONTRAINDICATIONS:** History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

**WARNINGS:** CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS

BEEN REPORTED FOLLOWING PARENTERAL THERAPY. A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

**PRECAUTIONS:** Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of  $\beta$ -hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

**ADVERSE REACTIONS:** *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihista-

mines available for emergency treatment. *Skin and mucous membranes*—Skin rash, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin—250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

**HOW SUPPLIED:** 250 mg and 500 mg Capsules—bottles of 24 and 100. Sterile Solution, 300 mg per ml—2 and 10 ml vials and 2 ml syringe. Syrup, 250 mg per 5 ml—60 ml and pint bottles.

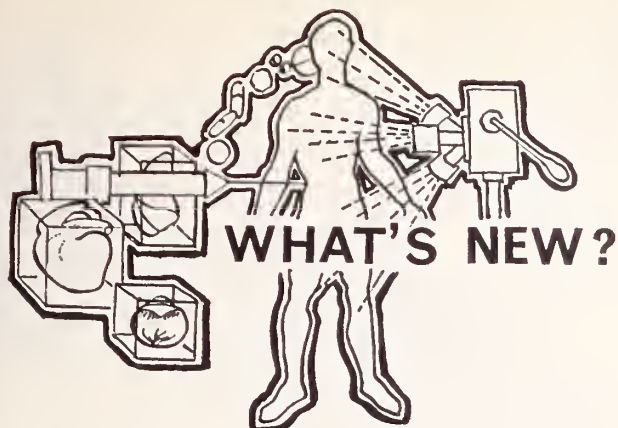
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## WHAT'S NEW?

Upjohn is introducing a new brand of sulfisoxazole. The brand name is Soxomide. It will be available in half-gram tablets. With the recently introduced brand of ampicillin, Pensyn, Upjohn offers such antibiotics as Panmycin, E-Mycin, Uticilin VK, and Sugracillin.

\* \* \*

The J. Walter Thompson Company announces the formation of a subsidiary, Synapse Communication Services, to produce a total audio-visual educational and training service for the health care industry. Its function will be to bridge the gap between the growing body of medical knowledge and the health care practitioners. JWT predicts that the health care industry will be the nation's largest industry by the end of 1973. Medical education, continuing education, recertification, and the training of para-medical personnel all require new techniques.

\* \* \*

Clin-Alert has published a ten-year Cumulative Index to adverse drug reactions. The Index for 1962 to 1971 is available at the price of \$36. Clin-Alert is a \$25 per year bulletin service published 30 times a year and devoted exclusively to reporting drug reactions. Write to Clin-Alert, P.O. Box 7185, Louisville 40207.

\* \* \*

Mead Johnson is introducing a new vitamin supplement called FEMININS.<sup>TM</sup> The new formulation supplies the vitamin and mineral requirements which are needed for women on oral contraceptives, by supplying increased amounts of vitamins B<sub>6</sub>, B<sub>12</sub>, and C, as well as folic acid and zinc.

\* \* \*

Behavioral Publications announces a new book "On Dying and Denying." Avery Weisman, M.D., is the author. Dr. Weisman has specialized in thanatology for the past 10 years. He introduces new concepts and terms in the scientific study of death. 207 pages, \$9.95.

\* \* \*

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# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545  
ANNUAL CONVENTION—OCTOBER 6-11, 1973—Indianapolis

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1—Gilbert M. Wilhelmus, Evansville (Chairman)	Oct. 1974
2—Paul W. Holtzman, Bloomington	Oct. 1975
3—Eli Goodman, Charlestown	Oct. 1973
4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
7—Joseph F. Ferrara, Franklin	Oct. 1975
8—Richard Ingram, Montpelier	Oct. 1975
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—James A. Harshman, Kokomo	Oct. 1975
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

## ALTERNATES

District	Term Expires
1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—William G. Bannon, Terre Haute	1973
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1975
7—Donald McCallum, Indianapolis	1975
8—Jack L. Alexander, Muncie	1973
9—Max N. Hoffman, Covington	1974
10—Martin O'Neill, Valparaiso	1975
11—Lloyd L. Hill, Peru	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1973

## SECTION OFFICERS 1972-73

### Section on Surgery:

Chairman—Malcolm L. Wrege, Indianapolis  
Vice-chairman—J. Robert Edwards, Auburn  
Secretary—Lowell Hillis, Logansport

### Section on Internal Medicine:

Chairman—Robert L. Rudesill, Indianapolis  
Vice-chairman—John L. Ferry, Hammond  
Secretary—Chas. W. Magnuson, South Bend

### Section on Family Physicians

Chairman—James T. Anderson, Greenfield  
Vice-chairman—James R. Daggy, Richmond  
Secretary—David M. Hadley, Plainfield

### Section on Obstetrics and Gynecology:

Chairman—Jerome F. Doss, Kokomo  
Vice-chairman—David E. Copher, Indianapolis  
Secretary—Charles R. Thomas, Indianapolis

### Section on Ophthalmology and Otolaryngology:

Chairman—Kenneth Isenogle, Fort Wayne  
Vice-chairman—Wallace Dyer, Evansville  
Secretary—David Kenney, Indianapolis

### Section on Anesthesiology:

Chairman—Willis W. Stogsdill, Indianapolis  
Secretary—David P. Lehman, Kokomo

### Section on Public Health and Preventive Medicine:

Chairman—Fred Poehler, La Fontaine  
Vice-chairman—Robert M. Seibel, Nashville  
Secretary—David Edwards, Indianapolis

### Section on Radiology:

Chairman—Dale B. Parshall, Elkhart  
Vice-chairman—James G. Lorman, Fort Wayne  
Secretary—L. Ray Stewart, Evansville

### Section on Nervous and Mental Diseases:

Chairman—Wesley A. Kissel, Indianapolis  
Vice-Chairman—Wallace R. Van den Bosch, Lafayette  
Secretary—Richard N. French, Jr., Indianapolis

### Section on Pathology and Forensic Medicine:

Chairman—Clyde Culbertson, Indianapolis  
President-elect—Wei-Ping Loh, Gary  
Secretary—Victor Muller, Indianapolis

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Vice President—John L. Cullison, Muncie  
Secretary—W. Thomas Spain, Evansville

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Vice-chairman—Howard R. Gray, Indianapolis  
Secretary—Victor G. Hackney, Indianapolis

### Section on College Health Physicians:

Chairman—John Miller, Bloomington  
Secretary—Wayne G. Pippenger, Muncie

## DELEGATES TO THE AMA

Terms expire December 31, 1972:

Delegates	Alternates
James A. Harshman Kokomo	A. Alan Fischer Indianapolis
Eugene F. Senseny Fort Wayne	Eugene S. Rifner Van Buren
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1973:

Delegates	Alternates
Jack E. Shields Brownstown	Patrick J. V. Corcoran Evansville
Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

## 1972-73 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Bernard B. Rosenblatt, Evansville	John Winebrenner, Evansville	May 10, 1973, Evansville
2.		J. S. Brown, Carlisle	Bloomington
3.	Claude J. Meyer, Jeffersonville	Robert K. McKechnie, Jeffersonville	September 1973, Clarksville
4.	Kenneth Schneider, Columbus	C. David Ryan, Columbus	May 9, 1973, Columbus
5.	James C. Lett, Greencastle	J. Franklin Swaim, Rockville	May 23, 1973, Greencastle
6.	John Moenning, Greenfield	Davis W. Ellis, Jr., Rushville	May 2, 1973, Rushville
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	June 6, 1973, Muncie
9.	Lowell R. Stephens, Covington	Theodore C. Person, Veedersburg	June 14, 1973, Attica
10.	Lambro Dimitroff, Hammond	Mario D. Mansueta, Munster	May 30, 1973, Hebran
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	Sept. 19, 1973, Logansport
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	Sept. 1973, Fort Wayne
13.	James Rimel, Plymouth	David L. Spalding, Mishawaka	Sept. 1973, Plymouth





# MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

Only a handful of some 2,600 health related bills introduced into the 92nd Congress have become public law. The most talked about pieces of health legislation over the past two years—national health insurance and health maintenance organizations—have been set aside for deliberation by next year's 93rd Congress.

After long years of debate by two sessions of the Congress, the Social Security catch-all legislation (H.R. 1) with its significant amendments to Medicare and Medicaid gained passage and has been signed into law by the President. Three of its measures are of major importance to physicians.

## Features of New Law Explained

First is the Professional Standards Review Organization (PSRO) proposal of Utah's Senator Wallace Bennett which is designed to improve quality and utilization review of health care on a national basis. This provision of the law stresses that over the next two years peer review will be concentrated in institutional settings rather than in physicians' offices, such review to be undertaken by physician organizations only.

Second, the new law stipulates that Medicare and Medicaid patients may receive care from health maintenance organizations (HMOs) but that federal reimbursement for such care will be no greater than for similar services rendered by non-HMO providers.

Third, the new law grants certain chiropractic benefits to Medicare and Medicaid patients. As passed by the Senate, chiropractic benefits were limited only to manipulation of the spine. In joint conference, House members further modified the Senate provision to require that chiropractic benefits be covered only after an x-ray revealed subluxation. The language of the law is not specific, but apparently the x-ray cost will not be paid for by Medicare, nor may the x-ray be interpreted by a chiropractor. However, this point will not be clarified until the regulations are written. The provision

also requires that chiropractors, in order to be reimbursed, must meet minimum standards established by the Secretary, Department of Health, Education and Welfare.

## Peer Review

Under the peer review provision of the new law, local medical societies will have the opportunity to establish peer review mechanisms, operating independently, to review the quality of care hospitals and nursing homes provide to Medicare and Medicaid patients.

Task of the PSRO is to "assure proper utilization of care and services . . . utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area."

The HEW Department could reach agreement only "with a qualified organization which represents a substantial proportion of the physicians in the geographical area. . . ." If this isn't achieved by 1976, HEW could turn to some other group to establish the PSRO.

A PSRO would be required to review only institutional care and services through 1975 unless it chooses—with approval of the government—to broaden the scope to include private practice.

During the pre-1976 period, 10% or more of the practicing physicians in an area could demand a poll of all practicing physicians to determine whether the organization negotiating to set up a PSRO substantially represents the physicians of the area. A more than 50% "no" vote would break off negotiations.

From now until the end of next year, the HEW Department is ordered to establish PSRO areas around the country (usually 300 or more physicians). In some cases it is believed that entire smaller states will be designated as PSRO areas.

In carrying out its responsibilities the PSRO would be required to review regularly provider and practi-

Continued



# COUNTY MEDICAL SOCIETY DIRECTORY

County	President	Secretary
Adams	Robert L. Boze, Berne	John E. Doan, 222 S. Second St., Decatur 46711
Allen (Fort Wayne)	Elfred H. Lampe, Fort Wayne	Thomas D. Foy, 1104 W. State Blvd. 46808
Bartholomew-Brown	Charles A. Rau, Columbus	Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Benton	A. L. Coddens, Earl Park	Edward L. Probst, 2760 25th St., Columbus 47201
Boone	Kathryn Jackson, Zionsville	D. L. McKinney, Box 398, Otterbein
Carroll	Alvan L. Eller, Flora	Gerald Fisher, 324 W. North St., Lebanon 46052
Cass	J. Carl Jones, Logansport	Robert Seese, 101 W. North St., Delphi
Clark	Claude J. Meyer, Jeffersonville	Joseph S. Bean, 1101 Michigan Ave., Logansport 46947
Clay	Forrest R. Buell, Clay City	George H. Rudwell, 207 Sparks Ave., Jeffersonville 47130
Clinton	George K. Hammersley, Frankfort	E. L. Conrad, 1207 E. National Ave., Brazil
Daviess-Martin	Clarence E. Snyder, Washington	Lee F. Dupler, 1258 S. Jackson St., Frankfort 46041
Dearborn-Ohio	Gordon Fessler, Rising Sun	Hamlin B. Lindsay, 511 E. Main St., Washington
Decatur	Ricardo C. Domingo, Greensburg	Leslie M. Baker, 501 Fourth St., Aurora
DeKalb	John H. Hines, Auburn	Alfredo Paje, Murphy Bldg., Greensburg
Delaware-Blackford	Harold E. Nelson, Muncie	Harland V. Hippensteel, 208 W. 7th St., Auburn 46706
Dubois	Arthur L. Wagner, Jasper	David J. Dietz, 2810 Ethel St., Muncie 47304
Elkhart	Thomas Quilty, Elkhart	Bernard Kemker, 111 Central Bldg., Jasper
Fayette-Franklin	Perry Seal, Brookville	Page E. Spray, 320 W. High St., Elkhart
Floyd	Marshall H. Buchman, New Albany	J. L. Steinem, 818 Grand Ave., Connersville
Fountain-Warren	Lowell R. Stephens, Covington	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fulton	Charles L. Herrick, Akron	Theodore Person, 601 N. Mill St., Veedersburg
Gibson	R. G. Geick, Fort Branch	F. Richard Walton, R. R. 2, Rochester
Grant	Larry K. Musselman, Marion	Roland E. Weitzel, 114 S. Hart, Princeton 47570
Greene	Robert Moses, Worthington	E. S. Rifner, Van Buren
Hamilton	R. Adrian Lanning, Noblesville	Harry Rotman, Jasonville
Hancock	Ben O. Singco, Greenfield	Joe R. Lloyd, 107 John St., Noblesville 46060
Harrison-Crawford	Louis Blessinger, Corydon	James T. Anderson, 120 W. McKenzie Rd., Greenfield 46140
Hendricks	Glenn Baker, Brownsburg	Carl Dillman, Binkley Bldg., Corydon 47112
Henry	O. Lynn Webb, New Castle	Donald Cheesman, 100 Meadows Dr., Danville 46112
Howard	John H. Elleman, Kokomo	Sam W. Campbell, 901 McCormack Drive, New Castle 47362
Huntington	D. Richard Gill, Huntington	Milo M. Sekulich, 1907 W. Sycamore, Kokomo 46901
Jackson-Jennings	Robert Greene, Rensselaer	Barth E. Wheeler, 818 W. Park, Huntington 46750
Jasper	George A. Donnally, Geneva	Slater Knotts, 650 Greenway Court, Seymour 47274
Jay	James Burcham, Madison	Kenneth J. Ahler, P. O. Box 317, Rensselaer 47978
Jefferson-Switzerland	Robert W. Ogle, Greenwood	Amin T. Nasr, Jay County Hospital, Portland
Johnson	Jack L. Shanklin, Vincennes	Ott B. McAtee, Madison State Hospital, Madison
Knox	F. X. Colligan, Topeka	Paul Reynolds, 1035 W. Jefferson St., Franklin 46131
Kosciusko	Daniel T. Ramker, Hammond	Rudsen M. Bueser, 410 South 7th St., Vincennes 47591
LaGrange	Clem H. Elshout, LaPorte	Roland Snider, 604 E. Winona, Warsaw 46580
Lake	Florian S. Dino, Bedford	Harley Flannigan, 213 W. Lafayette, LaGrange 46761
LaPorte	Franklin K. Beeler, Anderson	R. J. Bills, 504 Broadway, Gary 46402
Lawrence	A. G. Popplewell, Indianapolis	Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
Madison	Jose R. DeJesus, Jr., Plymouth	J. A. Carpenter, 900 I Street, LaPorte 46350
Marion	Maurice Sixbey, Denver	Mrs. Polly Dent, Exec. Dir., 1200 Michigan Ave., LaPorte 46350
Marshall	Carl B. Howland, Crawfordsville	L. E. Benham, 301 Stone City Bank, Bedford
Miami	William H. Jones, Martinsville	Ralph E. Reynolds, 458 Locust St., Middletown 47356
Montgomery	Benjamin Imperial, Kentland	Charles R. Thomas, 9009 E. Southport Road, Indianapolis 46259
Morgan	Max Sneary, Avilla	Mr. Arthur G. Loffin, Exec. Secy., 211 N. Delaware St., Indianapolis
Newton	Charles X. McCalla, Paoli	Lloyd C. France, 1223 N. Center St., Plymouth 46563
Noble	Glenn B. Mather, Bloomington	A. L. Baluyut, 29 E. Main, Peru 46970
Orange	J. Franklin Swaim, Rockville	W. E. Shannon, 215 Ward St., Crawfordsville
Owen-Monroe	Robert Gilbert, Tell City	Maurice A. Turner, 10 1/2 N. Main St., Martinsville
Parke-Vermillion	M. H. Omstead, Petersburg	John C. Parker, Goodland 47948
Perry	John A. Forchetti, Chesterton	Joseph Greenlee, Avilla
Pike	Paul Boren, Poseyville	Phillip T. Hodgins, Orleans
Porter	William R. Thompson, Winamac	James Ray, 1805 E. 10th St., Bloomington 47401
Posey	Frederick R. Dettloff, Greencastle	Antolin M. Montecillo, 3rd at Walnut, Clinton
Pulaski	C. R. Chambers, Union City	Robert A. Ward, Professional Bldg., Tell City
Putnam	E. H. North, Batesville	Donald Hall, Petersburg 47567
Randolph	W. H. Nutter, Rushville	Alfred J. Kobak, Jr., 1101 Glendale Rd., Valparaiso 46383
Ripley	Stephen R. Phelps, South Bend	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Rush	Benjamin Roberto, Austin	Charles Heinsen, Winamac
St. Joseph	David Silbert, Shelbyville	Edward Hannon, 407 Melrose Ave., Greencastle 46135
Scott	Michael O. Monar, Rockport	Susan Pyle, 1130 N. Columbia, Union City 47390
Shelby	Earl Leinbach, Hamlet	Manuel G. Garcia, R. R. 3, Batesville 47006
Spencer	Robert F. Barton, Angola	Charles Sheets, Manilla 46150
Starke	K. W. Eskew, Sullivan	Robert Nelson, 206 E. Bartlett, South Bend 46601
Steuben	John T. Burns, Lafayette	Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Sullivan	Jean V. Carter, Tipton	J. C. Bacala, 69 E. Wardell St., Scottsburg 47170
Tippecanoe	William H. Getty, Evansville	Harry Gordon, Ten Northridge Park, P. O. Box 70, Shelbyville 46176
Tipton	Werner L. Loewenstein, Terre Haute	John C. Glackman, Jr., Rockport
Vanderburgh	Michael Silvers, North Manchester	Robert J. Goode, 201 S. Heaton St., Knox 46534
Vigo	Peter B. Hoover, Boonville	Claude E. Davis, 1109 W. Maumee, Angola 46703
Wabash	T. K. Tower, Campbellsburg	J. S. Brown, Carlisle
Warrick	Tom H. Ebbinghouse, Richmond	Caroline E. Hass, 316 N. Salisbury St., West Lafayette 47906
Washington	Louis F. Bradley, Bluffton	Boyd A. Burkhardt, 202 S. West St., Tipton 46072
Wayne-Union	Gerald R. Bougher, Monticello	Mrs. Carole Rust, Exec. Dir., 421 N. Main St., Evansville 47711
Wells	Warren Niccum, Columbia City	J. Lewis Stoelting, 1724 N. 7th St., Terre Haute
White		William L. Purcell, Exec. Secy., P. O. Box 986, Terre Haute
Whitley		J. Dean Giffard, c/o Wabash County Hospital, Wabash 46992
		Robert C. Calvin, Newburgh
		F. T. Castueras, 906 W. Mulberry, Salem 47167
		John Dehner, Reid Memorial Hospital, Richmond
		Russell E. Graf, 1110 Highland Park Circle, Bluffton 46714
		W. Martin Dickerson, 1114 O'Connor Blvd., Monticello 47960
		V. P. Huffman, 201 N. State St., South Whitley 46787



tioner profiles of care and service (that is, the patterns of services delivered to Medicare and Medicaid beneficiaries by individual health care practitioners and institutions) and other data to evaluate the necessity, quality, and appropriateness of services for which payment may be made under the Medicare and Medicaid programs.

The PSRO would be expected to analyze the pattern of services rendered or ordered by individual practitioners and providers and to concentrate its attention on situations in which unnecessary, substandard or inappropriate services seem most likely to exist or occur.

A PSRO would have authority to approve the medical necessity of all elective hospital admissions in advance—solely for the purpose of determining whether Medicare and Medicaid will pay for the care. The PSRO would also be required to acknowledge and accept, in whole or in part, an individual hospital's own review of admissions and need for continued care, on a hospital-by-hospital basis, where it has determined that a hospital's "in-house" review is effective. It is expected that where such "in-house" review is effective this authority would be exercised by the PSRO. Similarly, a PSRO would be required to acknowledge and accept for its purposes, review activities of other medical facilities and organizations, including those internal review activities of comprehensive prepaid group practice programs such as the Kaiser Health Plans and the Health Insurance Plan (H.I.P.) in New York to the extent such review activities are effective.

The PSRO would (after reasonable notice) recommend to HEW appropriate action against persons responsible for gross or continued overuse of services, for use of services in an unnecessarily costly manner or for inadequate quality of services and would act to the extent of its authority and influence to correct improper activities.

Where a review organization finds that voluntary and educational efforts fail to correct or remedy an improper situation, it would transmit its recommendations concerning sanctions through a statewide council to the secretary of HEW.

The secretary could terminate or suspend Medicare and Medicaid payments for the services of the practitioner or provider involved, or assess an amount reasonably related to the excessive costs to the programs deriving from the acts or conduct involved.

A PSRO would have the responsibility of determining—for purposes of eligibility for Medicare and Medicaid reimbursement—whether care and services provided were: first, medically necessary; and, second,

provided in accordance with professional standards. Additionally, the PSRO where medically appropriate, would encourage the attending physician to utilize less costly alternative sites and modes of treatment.

The PSRO would not be involved with questions concerning the reasonableness of charges or costs or methods of payment nor would it be concerned with internal questions relating to matters of managerial efficiency in hospitals or nursing homes except to the extent that such questions substantially affect patterns of utilization. The PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that Medicare and Medicaid payments will be made only for medically necessary services which are provided in accordance with professional standards of care.

The local PSRO would be primarily responsible for review of all Medicare and Medicaid services rendered or ordered by physicians in its area. The purpose of the provision is to establish a unified review mechanism for all health care services under the aegis of the principal element in the health care equation, the physician.

### HMO Option

The legislation contains the Administration's request for allowing Medicare-Medicaid beneficiaries to enroll in HMOs, but limits the choice to existing prepaid group practicing plans by providing that incentive reimbursement would be available only to HMOs with a minimum membership of 25,000 and which have been in operation for at least two years. Instead of the Administration's plan for paying such HMOs 95% of the combined part A and part B costs of Medicare patients in an area, the bill sets out a formula under which HMOs would receive one half of the savings if care has been rendered for less than the Medicare average in an area (the so-called incentive reimbursement), but would have to absorb the entire loss if HMO treatment for Medicare beneficiaries runs higher than regular Medicare costs in the area.

The Joint Conference rejected a provision that would have made the federal government share in the losses of HMO care to Medicare patients, as well as a provision that would have established a bonus arrangement for states providing HMO care for Medicaid beneficiaries.

### Chiropractic

Inclusion of chiropractic benefits for the first time in a federal program was a setback to the medical pro-

Continued



# ISMA Committees and Commissions for 1972-1973

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fession, the Administration and numerous other anti-chiropractic forces. However, the modification of the chiropractic benefit language in conference may make it practically unworkable. As passed by the Senate, chiropractic benefits were limited to manual manipulation of the spine. In conference, this was modified to require that benefits would be covered only after an x-ray revealed subluxation. Apparently the x-ray cost will not be covered, nor can it be interpreted by a chiropractor, but these points will not be clarified until regulations are written.

Senator Edward Kennedy attempted by an amendment from the floor to strike the chiropractic provision, but it was soundly defeated by a vote of 66 to 6. Subsequently, the Massachusetts senator admonished the AMA for not supporting his amendment.

However laudable his effort, Senator Kennedy—an experienced parliamentarian—should have recognized that his attempt to strike the chiropractic provision had no chance of success. His amendment to H.R. 1 was unprinted, he introduced it from the Senate floor, and he proceeded without the cooperation of the bill's floor manager. That his approach was ill-advised from the standpoint of effective parliamentary procedure is evidenced by the amendment's lopsided defeat.

Prior to the introduction of his amendment, the Senator's staff was counseled by anti-chiropractic forces—including the AMA—that he did not have the votes. Further, it was pointed out that an overwhelming defeat of his amendment by a recorded vote would seriously hamper the Senate conferees in their efforts to bargain with members of the House in joint conference.

On several occasions in the past the Senate Finance Committee has added a similar chiropractic provision to a pending measure. But in each of these cases the Senate conferees later agreed to its deletion in joint conference with the House. In large part this was made possible because the chiropractic issue had not been singled out for separate vote on the Senate floor, and thus did not specifically pin down the Senate conferees.

In the latest instance, Senator Kennedy raised the issue singly and separately. Predictably, his amendment was roundly defeated.

Unfortunately, the effect of this was to impress the Senate conferees with the recorded wishes of the vast majority of their colleagues when they sat in joint conference with the representatives of the House. In conference, however, Rep. Wilbur Mills was able to modify the Senate language so as to require an x-ray determination of subluxation.

### Other Provisions

- Renal disease—individuals under the age of 65, covered by social security, would be eligible for Medicare if they require hemodialysis or renal transplantation. This is the second instance in the bill of extending Medicare to younger-than-65-people.
- Abusers—providers determined to have overused Medicare could have their services under the program terminated under stronger powers granted the HEW Department against abusers.
- Black lung—eliminated was a Senate provision that would have extended Medicare coverage to people receiving “black lung” benefits under social security.
- Publicity—adopted is a requirement that HEW Department make public information from a survey of health facilities or organizations on the absence or presence of “significant deficiencies.” Also the government must make public evaluations and reports dealing with individual contractor performances of carriers, intermediaries and staff agencies as well as program validation survey reports with names of individuals deleted.
- Joint Commission—HEW could enter into agreements to have states survey a hospital or hospitals certified by the Joint Commission on Accreditation of Hospitals on a limited basis where an allegation has been made that adverse health conditions exist.
- Eyeglasses, etc.—rejected was a senate provision adding to Medicare part B benefits for poor families the costs of eyeglasses, podiatric services, dentures and hearing aids.

Left intact in the measure is a limitation on physicians' prevailing charge levels under Medicare. Recognized as reasonable are only those charges which fall within the 75th percentile (a charge that covers 75% of the existing case charges for a procedure or treatment in an area excluding top 25% of charges), a step that Social Security already has carried out administratively. Starting next year, under the bill, future charge increases would be limited by a factor which takes into account increased costs of practice and the increase in earning levels in an area.

Stricken from the bill was a \$900 million provision to add drugs as an outpatient Medicare benefit, as well as a plan that would have established an Inspector General over Medicaid and Medicare in the HEW Department. ◀



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*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug products useful in treatment involving concomitant use of two or more drugs?**

**Opinion**

**Results of a questionnaire to 7,000 physicians:**

**62.9%**

**Believe combination drug products are useful.**

**13.8%**

**Do not believe combination drug products are useful.**

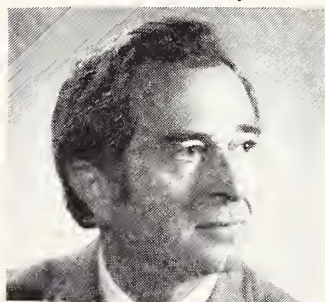


# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
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University of Rochester  
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and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years and that have an apparently satisfactory track record.

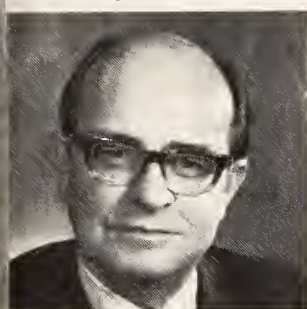
For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in one injection. This made for less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such preparation off the market doesn't seem to be good medicine, unless actual age showed a great deal of harm from the injection (rather than the proposed use) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.



# Maker of Medicine

W. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" denies the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the best of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible at some aches and pains all respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational. Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

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## Frostbite:

# A Review of Pathophysiology and Newest Treatments

DAVID L. RASMUSEN, B.A.  
ELVIN G. ZOOK, M.D.  
Indianapolis\*

**C**HILBLAINS, trench foot, immersion foot and frostbite are all the results of excessive and/or prolonged exposure to cold. The most common civilian cold injury is frostbite, usually involving the toes, fingers, ears, nose or chin. Prompt initial treatment and follow-up care can be a significant factor in decreasing the morbidity of this injury.

### Case Reports

**Case #1** — A 50-year-old Negro male fell on ice while intoxicated. Due to his inability to rise, he was exposed to a temperature of -6 F for approximately one hour. The patient was seen 12 hours after injury at Marion County General Hospital. Both hands were erythematous, non-cyanotic and painful with multiple bullae covering the dorsum of all digits and the thenar eminences. (1° and 2°)

\*From the Indiana University Medical Center and Marion County General Hospital. Mr. Rasmusen is a senior medical student and Doctor Zook is assistant professor of surgery (plastic) and chief of plastic surgery service, MCGH.

(Fig. 1) Treatment consisted of intravenous low molecular weight dextran, general supportive care, antibiotics and active range of motion exercises. One month after injury there was return of complete function in all fingers. (Fig. 2 and 3)

**Case #2** — A 58-year-old Caucasian male was found crawling on his hands and knees through the snow. He was exposed to a temperature of 0 F for approximately one and one half hours and was seen six hours after injury at Marion County General Hospital. Both hands were erythematous and non-cyanotic with multiple blisters covering all digits. There was anesthesia of all fingers except in the distal index phalanges. (1°, 2°, 3° on tip of right small finger) Treatment consisted of low molecular weight dextran infusion, general supportive care, antibiotics and active range of motion exercises. The skin loss on the distal phalanx of the right small finger healed and function returned fully.

**Case #3** — A 44-year-old Negro male fell on ice while in-

toxicated. Due to his inability to rise, he was exposed to a temperature of -17 F for approximately two hours. The patient was seen 24 hours after injury at the Veterans Administration Hospital (Indianapolis). The upper extremities distal to the wrist were cold, severely cyanotic and anesthetic with massive



FIGURE 1

Case #1 demonstrating blisters and swelling of 1° and 2° frostbite.





FIGURE 2  
Case #1 with full extension at six weeks.

edema and bleb formation with exception of the finger tips which were not swollen or blistered. (3° and 4°). (Fig. 4) Treatment consisted of immediate bilateral axillary sympathectomy, low molecular weight dextran infusion, general supportive care and antibiotics. Mummification occurred and was complete by six weeks. (Fig. 5) Bilateral amputation distal to the metacarpophalangeal joints and coverage with split thickness skin grafts was required six weeks after injury, but a portion of the thumbs was salvaged. (Fig. 6) Extensive tissue loss resulted in spite of complete care of the injury.

### Discussion

Frostbite causes cell injury with subsequent cell death. This is thought to be the result of direct damage by freezing and the secondary effects of cold-induced vascular changes.

Direct damage by freezing occurs initially by formation of ice crystals in the extracellular fluid. The crystallization is associated with the formation of a hypertonic solution in the extracellular fluid establishing an osmotic gradient between the intracellular and the extracellular compartment. The loss of intracel-

lular water produces dehydration and electrolyte imbalance, leading to protein denaturation and enzyme disruption.<sup>1, 2</sup>

Cold injury increases blood viscosity, leading to stasis, sludging, disturbance in the clotting mechanism and eventual massive intravascular thrombosis. Prolonged exposure to cold causes a sympathetic response and injury to the vascular endothelium. The injured endothelium has an increased affinity for

platelets, which combine with chylomicrons to form white emboli, leading to intravascular obstruction. The increased sympathetic tone causes intense vasoconstriction of the involved vascular bed, development of acidosis, decrease in the deformability of the erythrocytes, and an increase in the blood viscosity. The increase in the blood viscosity causes stasis and sludging with eventual widespread thrombosis and ischemic necrosis of tissue. Injury to the vascular endothelium allows the passage of plasma proteins through the vessel walls into the extracellular space, resulting in hemoconcentration. This leads to increased frictional resistance to blood flow and an increase in blood viscosity. The relative increase in intravascular fibrinogen levels augments erythrocyte aggregation by an unknown mechanism. Lastly, there is a rise in the serum lipid levels after the thawing of frostbitten tissue which also induces erythrocyte aggregation.<sup>3, 5</sup>

Cold injury is directly related to the degree of cold and the duration of exposure. During the Korean War, 90% of the cases of frostbite



FIGURE 3  
Case #1 with full flexion at six weeks.



occurred at a temperature near 20 F and after an exposure of seven to eighteen hours.<sup>7</sup> In civilians, the frostbite is usually due to a much lower temperature for a shorter period of time.

Humidity, wind and contact with water or metal facilitates more rapid transfer of body heat to the environment. Immobility is also a factor by impairment of circulation. Pre-existing arterial vascular disease and previous frostbite predisposes to frostbite injury.<sup>2</sup> The effect of previous frostbite may be the result of the persistence of local vasospasm or the result of "cold insensitivity" produced by initial frostbite and the consequent failure of the individual to protect the area.<sup>8</sup>

People living in the northern latitudes are less susceptible to frostbite. Experience has taught these people to protect themselves from the cold and they also appear to undergo acclimatization, possibly through a localized vasomotor adaptation. Rabbits placed in an ambient temperature of -6 C for 50 days



FIGURE 4  
Case #3 72 hours post frostbite. Note absence of bullae and edema of fingertip, indicating 3° frostbite.

had only 10% tissue loss when subjected to direct cold injury, whereas, control rabbits in normal temperature had 57% tissue loss.<sup>9</sup>

The clinical manifestations of

early frostbite are alternating periods of cold or discomfort (pain) in the injured area and a feeling of warmth. Often there is an accompanying feeling of joint stiffness.



FIGURE 5  
Case #3 10 days later with early mummification of fingers.



FIGURE 6  
Case #3 one week after amputation of necrotic digits. Note extensive loss of tissue.



**Table I****CLASSIFICATION**

- 1° EDEMA, ERYTHEMA, NO NECROSIS OR BLISTERS, TINGLING OR BURNING.
- 2° EDEMA, HYPEREMIA, BLISTER AND BLEB FORMATION, PARESTHESIA OR ANESTHESIA.
- 3° EDEMA, (BLUE, VIOLET, GRAY) DISCOLORATION, BLISTER AND BLEB FORMATION, GANGRENE OF SKIN AND SUBCUTANEOUS TISSUE.
- 4° PERSISTENCE OF GRAY DISCOLORATION, NO BLISTERS OR BLEBS, BLACK, MUMMIFIED, COMPLETE GANGRENE AND NECROSIS.

The frostbitten extremity in the unthawed state is usually waxy white with perhaps some mottling and a general sensation of numbness.<sup>10</sup> The classification of frostbite can be seen in Table I.<sup>2,11</sup> An ominous sign of eventual tissue death requiring amputation is persistence of cold, gray, numb tissue surrounded by erythematous, edematous, painful tissue within 24 hours after thawing. As the edema subsides, necrosis and gangrene become apparent and take as long as 60 to 90 days for demarcation to occur.<sup>10</sup>

After severe frostbite, the skin undergoes atrophy and keratinization. The connective tissue of the epidermis become sclerotic with loss of skin appendages. Muscle, peripheral nerve, blood vessel, periosteum and bone damage occurs.<sup>2</sup>

The prediction of tissue loss by history is not entirely accurate.<sup>13</sup> The clearance rate of Xenon 133 shows a 97% accuracy in predicting tissue viability but only a 74% accuracy in predicting tissue loss.<sup>14</sup>

**Treatment**

Great care should be taken to discover any contributing condition resulting in the frostbite. Frostbite should never be treated unless

adequate facilities are available, for, once thawed, severe damage will occur if the extremity is used for ambulation.<sup>10</sup>

Not only the frostbitten area but the entire body must be rewarmed. Rapid rewarming of the frostbitten extremity in water at 104 to 111 F for a period of 20 minutes or more is the method of choice. The use of a whirlpool is preferable. Local, rapid rewarming decreases the duration of the frozen state, thereby decreasing the time the cells are exposed to damaging electrolyte imbalance and prevents vessel damage resulting from slow rewarming. The rapidly rewarmed tissue has an accelerated inflammatory response, earlier healing and decreased permanent tissue loss. The effects of slow rewarming are so disastrous that it is better to stay frozen for extra hours while finding adequate treatment facilities than to undergo slow rewarming.<sup>2, 10, 12, 15</sup>

The rapid rewarming may be painful. Therefore, a combination of an intra-arterial or intravenous injections of 25 mg of an alpha blocker drug (Tolazoline) and an analgesic has been reported to give relief.<sup>11</sup>

The frostbitten part should be treated much as a burn. Aseptic precautions with sterile sheets elevated on a cradle and reverse isolation should be instituted. The involved area should be elevated and the patient placed on strict bed rest. Tetanus toxoid and/or antitoxin should be administered, depending on previous immunization history. If intact, the blisters or blebs should not be ruptured and a broad spectrum antibiotic should be used if infection develops. Tissue debridement is best accomplished by daily whirlpool treatments and only definitely necrotic tissue should be removed. Every attempt should be made to maintain the full range of motion of the extremity. The patient's diet should be high in protein

and supplemented by multiple vitamins and ascorbic acid. The use of tobacco should be discontinued, due to its peripheral vasoconstrictive effects.

No consistent benefit has been shown with the use of Heparin or other anticoagulants in the early management of frostbite.<sup>2</sup> The administration of low molecular weight dextran has met with mixed success. Some feel it inhibits intravascular erythrocyte aggregation, thereby decreasing blood viscosity,<sup>19</sup> but other experimental studies show low molecular weight dextran to be ineffective.<sup>4, 20</sup>

Intravenous Pluronic F-68, a non ionic surface active detergent, has been used successfully in the treatment of experimental frostbite. Knize<sup>4</sup> showed in rabbits that cold injury treated with intravenous Pluronic F-68 had only 58% necrosis compared with 100% necrosis in controls. Pluronic F-68 is thought to stabilize plasma protein and the erythrocyte membrane prevent the development of fat globules, decrease platelet adhesiveness and improve perfusion flow.

Experimental and clinical evidence indicate a beneficial effect from sympathectomy used in the acute treatment of frostbite and its sequelae. Golding et al.<sup>8</sup> treated six patients with bilateral third and fourth degree frostbite with unilateral regional sympathectomy. They concluded that: 1) earlier cessation of pain, 2) earlier and more distal diminution and demarcation of edema, 3) more rapid epithelialization, and 4) increased rate of healing in the extremity resulted on the sympathectomized side. Others have reported similar results.<sup>17</sup> Martinex et al.<sup>18</sup> demonstrated with arteriography the vascular lesions of frostbite in bilateral injury. Distal arterial spasm, arteriovenous shunting and arterial occlusion were seen prior to sympathectomy. One week after unilateral sympathectomy there



was no evidence of distal arterial spasm or arteriovenous shunting in the sympathectomized extremity, but it persisted in the unsympathectomized side.

Conservative amputation should be carried out only after definite demarcation has taken place. This may take as long as three to four months, and skin grafting sometimes becomes necessary after amputation in order to close the wound.

There are many sequelae of frostbite<sup>6</sup> (Table II) most of which are relieved by regional sympathectomy. Retardation of growth may occur in the young victims as a result of injury to the epiphyseal plate prior to the closure.<sup>21</sup>

We believe that frostbite is best treated by rapid rewarming, adequate local care, elevation, administration of low molecular weight dextran in second degree frostbite with addition of early regional sympathectomy for third and fourth degree injuries.

Careful debridement of tissue with conservation of all viable tissue is especially important in the frost-bitten hand.

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TABLE II	
SEQUELAE	
1. SUBJECTIVE	
Cold Hypersensitivity	82 %
Poresthesio	50 %
Hypesthesio	23 %
Poin ot Rest	16 %
2. OBJECTIVE	
Color Changes	73 %
Hyperhidrosis	57 %
Local Skin Changes	39 %
Hyperkerotosis	16 %
Transitory Edemo	5 %
Skin Atrophy	2 %
Transitory Blister	1 %

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Children are obese usually because of overeating. It is important to distinguish the few who have endocrine obesity.

# A Practical Approach to Children With Obesity

C. B. KIM, M.D.  
Columbus\*

OBESITY is a common problem in pediatric practice and is one of the most common causes of referral to the Endocrine Service of Children's Hospital, Department of Pediatrics, University of Louisville School of Medicine.

It has been our experience that these referred children rarely reveal endocrine dysfunction and in most instances rarely need any laboratory investigation to eliminate endogenous factors. It is necessary for the physician in pediatric practice to see simple and practical ways of approaching children with obesity, so that patients can avoid, if possible, the economic load of tests for endocrine dysfunction and unnecessary consultation.

## Discussion

It is vital to determine the height status as an initial step in the evaluation of the obese child. (Table I) Obesity in the short child is most likely to be related to endocrine dysfunction. Hypothyroidism, hypopituitarism and Cushing Syndrome result in relatively short stature. It is most unlikely that the obese, tall child (over 50th percentile in height) will demonstrate any endocrine disorder and these children may be classified in the exogenous group without any laboratory investigation unless other aspects of the physical examination are suggestive

of the other diagnostic groups. (See Table II) Extreme obesity is not the usual picture of hypothyroidism or hypopituitarism. A peculiar fat distribution occurs in Cushing Syndrome with obesity most marked around the posterior neck ("Buffalo Hump"), upper trunk and in the cheeks, with sparing of the extremities.

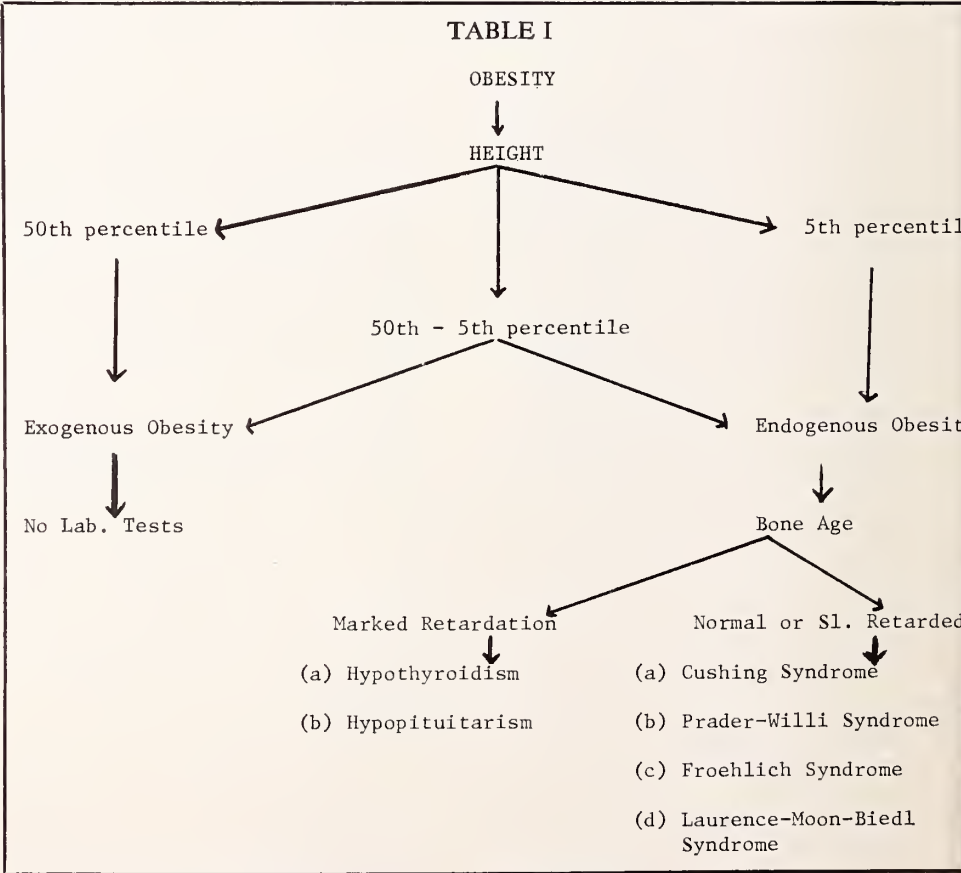
The next essential step in the evaluation of short, obese children with or without peculiar fat distribution is determination of skeletal maturation (bone age). A marked retardation of bone age (3-4 years

behind the chronological age) would favor either hypothyroidism or hypopituitarism. Laboratory studies for these are illustrated in Table III.

A normal or slightly retarded bone age (1-3 years behind the chronological age) would lead to the following various possibilities:

- (1) Cushing Syndrome
- (2) Prader-Willi Syndrome
- (3) Froehlich Syndrome
- (4) Laurence-Moon-Biedl Syndrome

Of these, Cushing Syndrome is



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TABLE II  
D. D. OF OBESITY BY PHYSICAL EXAMINATION

	<u>SIMPLE</u>	<u>CUSHING</u>
Obesity	+++	+
Height	Tall	Short
Fat Distribution	Generalized	Limited to face-neck-trunk
Skin Striae	Pale, Thin	Red and Purple
Hirsutism	+	++
Polycythemia	+	++
Strength	Normal	Decrease
Pulse Pressure	Wide	Narrow

TABLE III

Tests for the thyroid function

P.B.I. or T4  
T3 uptake  
Radioactive iodine uptake  
Cholesterol  
Alkaline Phosphatase

Tests for Pan-hypopituitarism

Thyroid: as above  
Pituitary—Adrenal axis  
Urinary 17-OHCS and 17-KS  
Metopirone test  
ACTH stimulation test  
Hypothalamico—Pituitary axis  
Skull x-ray  
Urinary gonadotrophin in adolescence  
Growth Hormone assay  
Posterior Pituitary  
24 hours urine output  
Serial urine specific gravity  
water deprivation test  
Pitressin response test

the principal entity to be excluded by laboratory tests and to be differentiated from simple exogenous obesity. The other syndromes are distinctive clinical entities and are rarely confused with other forms of obesity as they each show characteristic stigmata.

The Prader-Willi syndrome is characterized by obesity, mental retardation, hypotonia and hypogonadism<sup>2, 10</sup> These children are born small (small for gestational age) and no specific laboratory abnormalities have been described except they are prone to develop insulin resistant diabetes in late childhood.

Froehlich Syndrome with obesity, visual impairment and hypogonadism associated with hypothalamic tumor is very rare in children and an abnormality can be picked up by skull x-ray and pneumoencephalogram.<sup>1, 9</sup>

Laurence-Moon-Biedl Syndrome is characterized by obesity, mental retardation, poly-syndactyly with retinitis pigmentosa.<sup>8, 9</sup> A careful funduscopic examination is essential.

The Pickwickian Syndrome is a rare complication of extreme exogenous obesity, characterized by severe cardio-respiratory distress along with polycythemia, cyanosis, respiratory alkalosis and congestive

heart failure. Weight reduction is urgent in this case.

The diagnostic approach to obesity when the height status is between 3rd and 50th percentile is less clear cut. These children may be classified into either endogenous or exogenous groups. The physical findings, eating habits, growth pattern, family history and other various factors including emotional or social problems may be influential in determining whether extensive investigation is indicated. For example, an obese child who shows a recent ar-

rest of linear growth is a good candidate for endocrine investigation.

The major laboratory differential diagnosis of obesity in children will usually be between exogenous obesity and Cushing Syndrome (Table IV).

Cushing Syndrome is defined as a clinical and metabolic abnormality resulting from the excessive secre-

TABLE IV  
LABORATORY APPROACH TO CHILDREN WITH OBESITY  
(Normal or Slightly Retarded Bone Age)

	<u>Simple</u>	<u>Cushing syndrome</u>			
		Adrenal Hyperplasia	Adrenal tumor	Pituitary tumor	Ectopic tumor
Skull x-ray	Normal	Normal	Normal	Abnormal	
17-OHCS, KS	+	++	++++	++	++
Dehydroepiandrosterone	Normal	Normal	Elevated	Normal	Normal
Dexamethasone Supp. T.					
0.5 mg x 4	Yes	No	No	No	No
2.0 mg x 4	Yes	Yes	No	No	No
Metopirone response test	Yes	Yes	Negative	Negative	Negative
Plasma ACTH	Normal	+	Decreased	++	++++



tion of cortisol from either adrenal tumor, adrenal hyperplasia, basophilic pituitary tumor or rarely ectopic ACTH producing tumor.<sup>3, 4, 7, 9</sup> The elevation of 24-hour urinary 17-hydroxycorticosteroid (17-OHCS) and 17 ketosteroid (17KS) is more marked in Cushing Syndrome due to adrenal tumor and the excretion of urinary dehydroepiandrosterone is increased only in the patient with adrenal tumor. The basic test for differentiating each type of Cushing Syndrome is the dexamethasone suppression test.<sup>4, 5, 9</sup> In patients with adrenal hyperplasia there is a defect in the feedback mechanism of cortisol secretion with homeostatic receptors set at a higher level. Therefore, the pituitary is not suppressed by small amounts of exogenous dexamethasone (2 mg/day) but is by higher doses (8 mg/day). The cortisol secretion in patients with a tumor, either adrenal or pituitary, is completely autonomous and is not influenced by exogenous steroid administration. The same principle is applicable to the Metopirone test. Metopirone (SU-4885) blocks the 11-hydroxylase, an enzyme necessary for the cortisol synthesis. Because of the decrease of circulating cortisol, the normal inhibition of the pituitary is released and ACTH is secreted in greatly increased amounts. This in turn stimulates the adrenal gland to secrete an intermediate steroid, compound S, which is also measured in the Porte-Silber reaction for 17-OHCS. If there is a pituitary or hypothalamic defect such as pituitary tumor, the expect-

ed increase in urinary 17-OHCS does not occur. In adrenal tumor the secretion of cortisol is again autonomous and is not affected by Metopirone.

The key test between patients with adrenal tumor and ectopic ACTH syndrome is the measurement of the plasma level of ACTH, which is markedly elevated in the latter and low in the former. The high plasma level of ACTH is also seen in patients with basophilic pituitary tumor but marked elevation would favor the ectopic syndrome. A pituitary tumor, of course, should be easily diagnosed by skull x-ray and careful physical examination (papilledema, visual defect or the presence of increased skin pigmentation). Ectopic ACTH-producing tumors are very rare, especially in children, and the signs and symptoms of Cushing Syndrome are often mild, presumably because most have malignant disease and the duration is short. More than half the cases reported in the literature had bronchogenic carcinoma.<sup>6</sup>

### Summary

A simple practical way of approaching children with obesity has been discussed. In most cases, obesity is due to overeating and the physician in pediatric practice should cultivate an interest in the problem of childhood obesity and the specific problems which may be associated in each individual child. However, obese children who are short, who show marked retardation of skeletal maturation or who reveal

a rather peculiar fat distribution are likely to show endocrine dysfunction and consultation should be sought.

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The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complaints of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen\***).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E\***).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen\***).

Age 21, short, mammosome, with normal menses, some acne. Was put on pre-nuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E\*** or a sequential).





Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

\*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. has recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E\*** or **Ovulen\*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen\***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen\***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

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Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of sub-primate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnanediol determination.

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**Indication**—Enovid-E is indicated for oral contraception

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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# Three-Minute Electrophoresis for Rapid Identification of Hemoglobin S

WEI-PING LOH, M.D.  
Gary\*

Electrophoresis is essential for identification of hemoglobin S in sickle cell disease. The test previously requiring several hours to complete can now be completed in 20 minutes to one hour. The three-minute technique to be described here is believed to be the fastest existing. Also described will be a complete rapid system which is suitable for mass identification of hemoglobin S (Hb-S). The rapid system offers most in field testing when a high speed is needed and automated equipment is not available. The cost involved is minimal.

## Materials and Methods

Heparinized capillary tubes are used to collect finger blood. One drop of the collected blood is placed on a piece of parafilm. Under the parafilm is piece of thick cardboard which carries a number of circles and specimen identification numbers. One circle with its identification number is assigned to each blood specimen and can be clearly seen through the semitransparent parafilm. Equipment and reagents for Zip Zone† ELECTROPHORESIS is used. The drop of blood specimen on the parafilm is immedi-

ately mixed with two drops of hemolysate reagent, using the tip of a wooden stick to mix for 15 seconds. In case of significant anemia with decrease of hemoglobin only one drop of the hemolysate reagent is needed for the mixing. The prepared specimen along with control is then transferred to a sample plate and is finally applied to a cellulose acetate plate for electrophoretic chamber which contains buffer at a pH of 8.6. As many as 40 specimens may be applied to one plate and 120 specimens may be simultaneously analyzed in one chamber. Several chambers may be connected to the same power supply. Detailed instructions from the manufacturer should be followed. At 450 V for 3 minutes we can clearly see the separation between Hb-A and Hb-S which enables us to differentiate between sickle cell anemia and sickle cell trait. Separation between Hb-S and Hb-C can be seen at this stage or may require two or three additional minutes of running time for better separation. The separation record can be easily photographed and does not require permanent staining. In absence of scanning machine one can perform semiquantitation of Hb-S by comparing the color of S-band from the patient against the colors of several known quantities of Hb-S in controls. This method of quantitation, however, lacks practical value.

The author<sup>1</sup> has previously suggested a hematocrit determination and a blood smear examination during mass screening and identification for Hb-S. In such case the patient's blood can be mixed with

hemolysate reagent in the micro-hematocrit capillary tube during centrifugation.

## Comment

The rapid test tube turbidity test for detection of Hb-S previously described by the author<sup>2,3</sup> requires 5 minutes to complete and has been widely used for screening. Positive results require additional testing by electrophoresis in order to differentiate between sickle cell anemia and sickle cell trait. With the advent of the rapid electrophoresis described above it is no longer practical to use the tube screening test first, since the direct use of the electrophoresis is just as fast as the rapid test tube test and, in fact, offers more information. The initial cost for the equipment and reagents used in the electrophoresis is approximately \$425.00. With large quantity of blood specimens in field and mass testing the cost of electrophoresis can be brought down to less than five cents per test. This figure compares favorably against 48 cents per test for the reagent used in the tube screening test. Further study on the rapid electrophoresis is still in progress and more findings will be elucidated in a future report.

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†The equipment and reagents were manufactured by the Helena Laboratories, Beaumont, Texas.



# Mechanisms of Drug Interactions

## Part I

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THE average hospitalized patient receives from 7 to 10 drugs concurrently at each visit.<sup>1</sup> The increased potencies and numbers of new drugs available make the problem of adverse drug interactions much more significant. The questions of import are (1) can we predict these interactions before they occur, thereby avoiding them? and (2) which of the predicted and observed adverse interactions are of clinical significance? The purpose of this review is to present general principles which are useful in understanding drug interactions that occur in significant clinical numbers.

There are six basic categories of drug interactions. They are: (1) Drug interactions that occur outside of the patient, i.e., drugs that possess physical incompatibilities, such as mixing dimethyltubocurarine (an acidic drug) with thiopental in an I.V. drip (an alkaline drug) resulting in dramatic loss of potency of the dimethyltubocurarine. (2) Drugs that interfere with absorption or distribution of one another by various mechanisms. (3) Drugs that interfere with the metabolism of other drugs, resulting in either increased or decreased drug activity. (4) Drug interactions that result in alteration or elimination of a drug. (5) Drug interactions that occur at various receptor sites on biological membranes, resulting in prolonged

or decreased drug effects. (6) Drug interactions that occur because of the pathological condition of the patient, such as dehydration or other conditions resulting in electrolyte imbalance.

### Drug Interactions in Vitro

The first category of physical drug incompatibilities is illustrated by the following examples. Advantages of the interaction of EDTA chelation *in vivo* of lead or other heavy metal poisoning to facilitate the removal of the toxic compound has long been useful in medical practice,<sup>2</sup> but the disadvantage of chelation of tetracyclines by divalent ions such as magnesium or calcium interfering with its absorption from the gastrointestinal tract only recently has come to light.<sup>3</sup> The chemical inactivation of the acidic drug dimethyltubocurarine in an alkaline solution of thiopentothal is noted in its package insert. Good reviews of such physical incompatibilities are found in Pelissier and Burgee<sup>4</sup> and Elking and Kabat.<sup>5</sup>

### Drug Interactions in Vivo

When one considers the various drug interactions that occur within the body, one must first review some principles of pharmacodynamics (pharmacokinetics). This subject is concerned with the absorption, distribution, biotransformation and excretion of drugs. These factors, coupled with the drug's dosage,

determine the concentration of a drug at its site of action. Such concentration reflects both the intensity and time-course of the drug's therapeutic effects. The most important fact to remember is that only FREE drug is capable of reacting with the locus of action of a drug, commonly referred to as the drug receptor. Only FREE drug will be absorbed in its nonionized form through cell membranes into the plasma from all routes of administration, excepting I.V. Again, it is FREE drug that passes into tissue storage areas and FREE drug that is biotransformed into inactive metabolites and excreted. At all other times the drug is bound to various components of body tissue, such as albumin, adipose tissue, enzyme or cell membrane structures. This phenomenon follows the laws of mass action, and as such an equilibrium exists between the free form of the drug and its bound form. Thus, any physical factor, physiological alteration or other drug that affects the amount of free drug available has the potential to produce a drug interaction. The magnitude of this interaction determines whether it is of clinical significance.

### Drug Interactions Based upon Interference with Absorption

Absorption is a process whereby a drug passes through cell membranes from one compartment of

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the body into another. The cell membrane is made up of a bimolecular lipid membrane with water-filled pores<sup>6</sup> and controls the absorption process. Most drugs are weak acids or weak bases and are present in solutions as ionized and nonionized forms. The ionized portion of a drug diffuses through the limited water-filled pores, whereas the nonionized rapidly diffuses through the lipid membrane. Therefore, changes in the acid-base balance of the body may have profound influence on drug absorption.<sup>7</sup> For example, phenobarbital is a weak acid and is absorbed primarily from the gastric mucosa in its nonionized state. However, in a patient currently taking antacids for an ulcer condition, phenobarbital absorption will be delayed because antacids increase the degree of ionization of the drug.

The same principles of drug absorption apply in the small intestines. Although still on the acidic side (pH 5.3), it is a less acidic (more basic) environment than the gastric mucosa. Thus, a drug that is a weak base is less ionized and more rapidly absorbed from the intestine than from the stomach. An example of such drugs would be morphine, ephedrine, and tolazoline. If these drugs were administered with antacids, a more rapid onset of activity would be noted.<sup>7</sup>

Intestinal motility is also an important factor governing drug absorption, as it affects the length of time a drug is in contact with the absorbing membrane. The interaction to be considered here is the patient who is on maintenance medication, such as digitoxin or warfarin and is given the antibiotic, ampicillin. Ampicillin is noted for its diarrhea-producing qualities in many patients<sup>6</sup> and when such a side effect develops a decrease in maintenance dosage and drug efficacy is seen. On the other hand, many drugs have anticholinergic

properties that delay a weakly basic drug absorption from the intestine as it remains in the acidic stomach for prolonged periods. The tricyclic antidepressants and major tranquilizers (phenothiazines) and meperidine have pronounced anticholinergic activity and are given in combination with many other drugs possessing anticholinergic activity (such as quinidine), resulting in marked peripheral vasodilation, excessive dry mouth, and paresthesia.<sup>8,9</sup>

Other drug absorption interactions can be cited, such as the case of diphenylhydantoin (DPH) inhibiting the absorption of folic acid. This occurs because DPH inhibits the intestinal enzyme conjugase, which is necessary for the conversion of natural folate polyglutamate into the monoglutamate form necessary for absorption of folate from the intestine.<sup>10</sup> This interaction may result in megaloblastic anemia.<sup>11</sup>

Absorption processes that often are not emphasized include active transport and carrier transport (facilitated diffusion). The most familiar example of a useful drug-interaction utilizing transport system is that of probenecid being used to block the secretion of penicillin in the renal tubules resulting in prolonged levels of penicillin.<sup>6</sup> This same system is involved in an adverse drug interaction when aspirin (ASA), in low dosage, interferes with the uricosuric action of phenylbutazone. The secretory system for uric acid in the renal tubules is inactivated with 1-2 gm daily dosage of ASA, resulting in an increased uric acid level in the plasma and less efficient uricosuric activity of sulfinpyrazone or phenylbutazone.<sup>11</sup> In general, any acidic, nonmetabolized drug (e.g., thiazide diuretics) will be secreted by the renal tubules and may interact with any other compound acting through this same transport mechanism.<sup>12</sup>

## Drug Interactions Based upon Protein-binding Changes

Once a protein-bound drug is absorbed into the plasma an equilibrium is reached between free drug and bound drug. This may lead to drug interactions by the first drug being replaced by the second drug on the plasma protein.<sup>13</sup> A bound drug is considered inactive, as it is not in free form to diffuse to the receptor site. When the binding capacity of the plasma albumin amino groups is exceeded, more free drug is available to react in the body.<sup>12</sup>

The protein-binding capacity of human plasma albumin for a drug of a molecular weight of 200 is approximately 200 micrograms per ml.<sup>12</sup> If the drug, warfarin, is 98% protein-bound, then 2%, or 4 micrograms, is in the free form to produce its pharmacological effect. If another highly acidic-bound drug, such as phenylbutazone, is given that competes with the amino-binding sites on the albumin molecule to such an extent that only an additional 2% of the first drug is displaced, then 8 micrograms per ml is the resulting blood level of Coumadin. In effect, the therapeutic activity of Coumadin has been doubled without increasing the daily maintenance dosage. Such a clinically significant interaction has occurred as evidenced by precipitated bleeding in patients.<sup>14</sup> Other drugs known to undergo similar reactions with warfarin sodium are indomethacin, oxyphenbutazone and clofibrate.<sup>12</sup> Aspirin has been demonstrated to displace chlorpropamide, resulting in a hypoglycemic episode with normal daily maintenance doses of the latter drug, and with methotrexate, resulting in enhanced toxicity of this compound.<sup>16</sup> A general rule is that any highly acidic-bound drug given with another such compound represents a potential interaction by mutual dis-



placement. By interpreting the degree of plasma-binding of the drug or its pKa, usually found in the package insert, one can ascertain whether such potential exists.<sup>12</sup>

A subsequent article will consider the remainder of the basic mechanisms of drug interactions. Those occurring by changes in tissue-binding sites, drug metabolism characteristics, renal clearance phenomenon, receptor availability and specific pathological conditions will be discussed.

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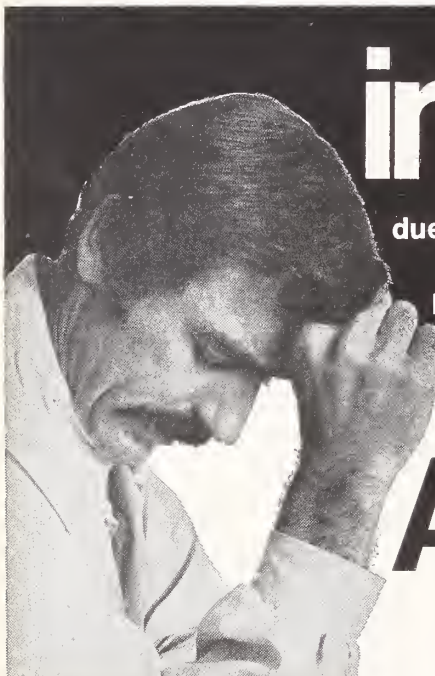
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## AMA 1972 Opinion Survey

THE Opinion Survey conducted this year by the AMA received a most cordial and enthusiastic response in Indiana.

The questionnaire was returned by 55.6% of all Hoosier doctors to whom it was mailed. The opinions from Indiana were very close to those expressed by the country's doctors as a whole, but there were some significant differences.

The first question concerned attitudes toward government health plans. The total U.S. vote was 73.1% in favor of retaining as many as possible of the basic principles of private practice. The Indiana vote for this choice was 68.4%. The difference was that 22.6% of the Indiana respondents voted in favor of resisting any form of government health plan except that limited to medical and related care for the poor. The national vote was lower—16.4%.

Question number two concerned sentiment for or against proposals before Congress for national health insurance. The majority of physicians nationally and in Indiana voted either for the AMA Mediredit Plan or for a plan to limit federal assistance to catastrophic coverage only. Mediredit got 50.1% favor-

able response in Indiana and 55.7% nationally. The five percent difference in Indiana went to the "catastrophic coverage only" item—19.1% voted yes in Indiana, 14.1% nationally. The other suggested plans, all other responses and undecided voters registered only small percentages in the voting both here and over the nation.

Question III was about non-institutional non-governmental arrangements. Fee-for-service without prepaid capitation was big in Indiana, with 75.9% positive responses as contrasted to 66.6% for the U.S. The difference in this case appeared to be on the "Contract practice (prepaid capitation system) in which you are reimbursed on a fee-for-service basis" choice. Here only 14.9% voted yes in Indiana, while 21.0% chose this way nationwide.

What would you do if national compulsory health service were adopted by Congress? This was question Number Four. It produced a wide spread of votes here and nationally. "Leave the practice of medicine," however, produced 9.0% yes votes in Indiana, and only 7.6% nationwide.

On Question Number Four more Hoosier doctors and more doctors nationally voted for "continuing pri-

vate practice with those patients who would pay my private fees, whether or not the patient pays an additional mandatory federal premium." This choice got 29.7% of the Indiana votes and 28.1% of the U.S. votes.

Number Four produced almost as many votes for Joining the Federal Program and practicing in it: 21.0% in Indiana and 24.6% nationally. The undecided faction on this question was the largest of any of the questions asked. 23.1% were undecided here and 21.6% in the country as a whole.

Nearly three-fourths of doctors in Indiana and also in the U.S. feel that extra laboratory and x-ray tests are ordered today to attempt to avoid malpractice situations. Slightly over one half in both categories felt that extra consultations are also obtained for the same reason. Almost half the respondents also thought that extra hospitalization resulted from malpractice problems.

The question concerning agreement with the amount of emphasis placed by the AMA on various activities produced a remarkably uniform response. Indiana doctors voted almost exactly in the same proportion as did their colleagues elsewhere.



A considerable majority of the respondents felt that proper AMA emphasis was placed on scientific activities, medical education, continuing education, membership benefits, and on communication to the medical profession.

A majority of responses indicated that most physicians felt that AMA was not putting enough emphasis on communication to the public. About one-third of the voters thought that not enough emphasis was being placed on practice management problems and on socioeconomic issues.

## Guest Editorials

### Pre-Hospital Emergency Care of the Heart Attack Patient

**E**MERGENCY medical care of patients with a coronary heart attack is divided into pre-hospital and in-hospital phases. In-hospital treatment made excellent progress during the last decade with the development of coronary care units. Pre-hospital treatment has lagged behind.

Mobile emergency rooms and coronary care vehicles deliver medical care to patients quicker and more efficiently. Equipped with monitors, shock equipment and drugs they allow trained personnel to treat patients on the spot and enroute to the hospital.

Nothing has been done to sustain life until a mobile unit arrives. Now an attempt is being made to provide that missing but essential link. The American College of Physicians has embarked on a mass educational program on cardiopulmonary resuscitation. This prestigious society, by using the expertise of 20,000 members, hopes to implement this life-saving training program on a nationwide basis.

Cardiopulmonary resuscitation combines mouth-to-mouth respira-

tion and closed heart massage. The latter is accomplished by applying downward pressure on the breastbone with the palm of the hand. By squeezing it toward the backbone, the heart is compressed and blood is forced out into the general circulation. A sudden release of pressure causes the heart to suck blood back into its chambers. If repeated once a second and accompanied by blowing air into the lungs through the mouth (12 times a minute), life can be sustained for periods in excess of 30 minutes.

The knowledge gained in coronary care units, by monitoring patients for long periods, has shown that when the heart stops beating or is rendered inefficient by a rapid or irregular rhythm, it must be restored within four minutes to preserve the brain.

When cardiac arrest occurs in the street, restaurant, theater, sports stadium, golf course or home, it is difficult to provide professional care within that critical period. The number of sudden deaths due to heart attacks annually is about 350,000. To save some of them we will have to teach all old enough to understand, the simple but effective resuscitative procedure outlined above. By instructing a large number, help for those stricken may be at his side. Sustaining life until professional help arrives will save thousands of victims each year. The risks involved if the procedure is performed improperly include damage to ribs and bruised organs. Some people may not have a coronary. Subjecting them to resuscitative procedures will do no harm and potential for good greatly outweighs the risks involved.

The College of Physicians, in cooperation with the Heart Associations, will urge physicians to join in this national effort. Demonstrations on mannequins and movie films will be used to train the general public.—Excerpted from an

article written for the AMA Commission on Emergency Medical Services by J. E. Stolfi, M.D.

## Consumerism— A Cutting Edge

**S**UDDEN, unexpected energy exchanges, "accidents," are finally receiving some of the attention merited by their importance in the morbidity-mortality spectrum of Americans. Considering that more children of ages 1 to 14 die each year in automobile crashes than from meningitis, heart disease, pneumonia and congenital malformations combined,<sup>1</sup> and that more productive man-years are lost through accidents than through cancer and cardiovascular disease,<sup>2</sup> one can only be appalled at the long-standing apathy of Americans and their leaders, and most of their physicians, towards this group of problems.

Although properly fastened lap belts prevent serious injury with an efficacy of 65% or more, neither children nor adults, unfortunately, are likely to be using them at the time of a crash. A recent study showed that only about one third of parents restrain their children with seat belts during automobile trips in the city and country, and less than half of the families' pediatricians advise them about the proper precautions to take when riding with children in automobiles: seat them in the rear, fasten their seatbelts, and lock the doors.<sup>1</sup>

For the growing number of persons wishing to prevent serious injury to children, which of the auto safety restraints available are the most effective, how much do they cost, and where can they be purchased? A consumers organization recently tested 17 child restraint systems, using a deceleration sled and instrumented dummies to represent three-year-old children. Although all systems complied with Federal



vehicle safety standards, only three satisfactorily protected the child's head, body, and tissues from hostile surfaces, hazardous torsions, and the g's of rapid deceleration in simulated front and rear-end crashes.<sup>3</sup> All the other 14 systems were unsatisfactory. The report recommended stronger government standards for children's restraints.

Significant among man, vehicle, and road interactions in automobile crashes is the phenomenon of skidding, which is especially related to properties of the road surface, either wet or dry.<sup>4</sup> Aquaplaning, which occurs when tire surfaces lose contact with the road surface because of an interposed layer of water, precludes steering the vehicle and appears to predispose to skidding. It is known that in water 2 mm deep, even a vehicle with new tires cannot be steered if it is traveling more than 66 mph.<sup>5</sup> If the vehicle's tire tread is only 3 mm deep, the car cannot be steered in 2 mm of water at a speed greater than 36 mph. But aquaplaning can be wholly prevented by driving at a low speed in wet weather and maintaining tires with good tread depth.

Suppose a person has tires with less than 2 mm of tread, the minimum depth recommended for safe driving. How can he select new tires with adequate rupture resistance, stopping ability, steerability, and tread life, all at a reasonable price? The same consumers group provided useful data about this question by testing major brands and describing the interesting results.<sup>6</sup> In standardized tests which compared tires of radial, belted, and bias-ply construction, some heavily advertised brands ruptured, or failed to survive high-speed, long distance driving or simulated rough road in safe condition.

When people band together as users of goods and services, they can provide unique resources, unaffected by corporate pressure

groups and the inertia of most government bureaus, for testing quality and safety. Such consumer groups, sometimes in competition with each other, have tested and compared thousands of products with everyday usefulness, from aspirin and unsafe drugs, through family doctors, to salmonella in sausages and zwieback for children. Their reports often emphasize user-health and product safety, and for this they deserve the attention and support of persons interested in preventive medicine.

A young lawyer speaks and writes about an automobile with unstable handling characteristics, and an industry's lack of concern for product safety; a state insurance commissioner from Pennsylvania describes how to select the best and least expensive hospitals, and how to avoid unnecessary surgery; and a consumers group tests auto safety restraints for children and new tire performance. Of such diverse actions is the consumerism movement made, a keen yet flexible cutting edge against the stubborn obstacles of some of our most important, and most neglected, health problems.

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## Response for the 50-Year Club by David H. Sluss, M.D.

AFTER 50 years in active medical practice and 75 years of living, I can reflect upon the many material and ideological changes I have experienced and observed. Pondering over the miraculous advances in the field of medicine—such as heart and kidney transplants, lung resections and brain surgery—the technical development of the automobile, aeroplane, radio and television—the scientific advent of atomic energy and the bomb, and walks on the moon—the word “fantastic” is conjured up. Or, as a skeptical Frenchman might remark, “formidable” with the connotation of amazement but with a subtle background of fear. This conception of fantastic, then, suggests a relationship to fantasy, to mystique and to myths. This idea of myths seems quite relevant or “relates,” to use the popular expression. One hears and reads, as aptly outlined in the *Wall Street Journal* of September 1, 1972, of many myths and fantasies accepted as facts and truths in our current ethos. The hippie culture, free sex, Satan worship, voodooism and occultism all seem to draw the interest and attention of many, both young and old.

Although there have been many tangible improvements in medicine, and notable progress in our society and culture, the basic motives of mankind still function without change. The realistic French have a quotation “La plus ce change, c'est la meme chose,” which translates to “the more it changes, it's the same thing.” Thus youth has the primary and essential urge and challenge to climb the mount of Venus. With this project accomplished, more or less successfully, he then searches and strives to acquire power in one or



more of its various manifestations. The doctor, for example, is motivated by the search for power over suffering and pain, and even over impending death. The *dedicated* minister, priest or rabbi is inspired by the thought, that through his evangelical power he is saving souls for eternity. To be sure, impiety and apostasy are often found where Communism has infiltrated the religious field. The banker and financier exercise commanding power through the uses of money and credit. The professional soldier, always aiming at promotion, feels his absolute power over soldiers on the battlefield. Politicians and lawyers, bent upon improving the Nation, exert power to control and direct the lives of people by passing laws and regulations with punishments and rewards. Then, at last, man begins to ponder over the hereafter and to try to make adjustments and amends which he feels are necessary for meeting his Maker.

I well recall my grandfather's privy with the corncobs and Sears Roebuck Catalogue. Now we have soft perfumed tissue decorated by pink and blue fleur de lys, yet the end is pretty much the same.

On the other hand there are two things we can count on besides death and taxes. The first is change. Change will take place constantly, with us or without us or our co-operation. The second thing we can count on is human resistance to change. As one reaches maturity, resistance to change becomes rigid and unyielding. Most of the dialogue in the news media is between those who recognize changes that have already taken place and those who resist. Change however, does not necessarily guarantee progress or improvement. Deterioration and regression may result, as well.

Most doctors are interested primarily in the unhindered practice of medicine and devote their entire time and energy in that pursuit.

However, strict attention to specialization, although essential in medical progress, presents a weakness. It is the failure to view the overall picture and to recognize and to try to direct the many impending changes which threaten our medical system.

### Medical Care "A Good Bargain"

Contrary to propaganda in the news media and from politicians, with their myths about the serious medical crisis demanding drastic alteration, there is no doubt in my mind but that medical care in the United States is a good bargain. Compared to service in other countries as I have observed over the years, during fairly extensive travels and study abroad, ours is the best. Medical education in the great centers of Europe, for centuries the Meccas for medical training, has been replaced by the tremendous medical facilities in the United States, developed through the free enterprise system.

It is true that the life span of about 70 years for man has not materially lengthened with our increasing scientific knowledge. Alcohol, drugs, smoking, obesity, the pressures of taxation and intensive competition, automobile and industrial accidents and failure to assume personal responsibility for individual health—these things have nullified to a great extent the benefits of preventive medicine and medical treatment.

I look back upon my student and intern days with a degree of distress and regret, now that I see the benefits of fine medical care and the results of research. I visualize the ward with patients suffering from all the dreadful complications of typhoid fever, and remember the feeling of hopelessness while watching pneumonia destroy robust young men. I still can smell the odor of pus and smallpox in the old pest-house and remember the horror of

the ward with cases of terminal tuberculosis—the terrible emaciation, coughing and putrid expectoration. These are conditions medical students of today would never see here. To be sure, there are still many places in the world with an even more horrible plight which we are helpless to correct.

I have operated on a patient with acute appendicitis on the kitchen table while the old country doctor poured chloroform, the only anaesthetic he knew how to use, and with a good result.

It used to be the practice in the great charity hospitals that the newest intern or house officer was often assigned the job of anaesthetist. The intern with his ethyl chloride and a can of ether was completely unaware of such a complication as cardiac arrest. Although, of course, at times when his mind drifted off about his next date (no intern could think of marriage on \$25 a month), he thoughtlessly poured too much ether and the patient stopped breathing and turned blue in the face. But with a scowl from the surgeon and a few pressures on the chest, the patient quickly recovered when the mask was removed.

Looking back on my childhood I remember the coaloil lamps, replaced by gas and then electricity, candles on the Christmas tree, the squeaking victrola with John Phillip Sousa's, "The Stars and Stripes Forever," street cars, and our horse and buggy. With a dime's worth of steak and a five-cent loaf of bread my mother could prepare a fine dinner. We were happy then and had confidence and a sense of security in the expectation that if we did right and worked hard the end would be good, otherwise we could go off to the county poor house, with no thought of any support or aid from Washington.

. . . .

My recollections go back for more than a century. My grand-



father often told of his experiences in the Civil War and my grandmother recounted in detail the struggles and joys of her young life with grandfather on their farm. I saw my father in his blue uniform with his dangling sword ride off on old Trixie during the Spanish American War. In the First World War, I was a buck private in the rear rank in the SATC, marching with my oversized overcoat dragging on the ground in the snow. I swore then in my mind that I would definitely be an officer in the next war, which I felt was certain to come. In World War Two I served in Persia, working with the Russians, and witnessed with dismay the intrigue and the tremendous expenditure of our wealth given away to an evident enemy which our president extolled and classified as our "Gallant Ally." All the while we were being stabbed in the back at every opportunity and the Russians laughingly remarked, "We are not your allies, we are co-belligerents." They may have been honest and truthful about this but we were fools not to see their duplicity. Following the disastrous Teheran Conference I sensed the rapid decline of American and British prestige as I traveled throughout the Middle East. Now I am an interested observer in the last and final phases of a continuing undeclared ideological war against our religion, our freedoms and our liberty, which most Americans do not seem to see or understand or care about or show much indication of wanting to win.

....

In my student days we looked upon socialism as sort of a joke alien to American character and custom. The medical school started a course of indoctrination in social science but no one paid much attention. But now the medical schools and universities subsidized by government grants are knee-deep in the left-wing movement. Appar-

ently the students, brain-washed by socialist propaganda and doctrine under the guise of humanitarian motives, seem to like it. As Voltaire observed, "Man is a rascal, he can get used to anything," as seen in Russia and Red China where there is no alternative but to enjoy life under socialism, since any objection is met with a gun, Siberia or the insane asylum.

One of the many myths advanced for improving medical care is the idea that there is a serious medical crisis in the ghettos. There is no such thing as a ghetto in the United States. Every city has slums and always will have. This so-called crisis, in order to be corrected, is said to require replacement of our system by national medicine. To counter this myth it is only necessary to get a clear picture of actual statistics regarding health care as detailed in Marvin Edwards' book, "Hazardous to Your Health," and not those so widely published by the advocates of socialized medicine. Another very amusing myth which assures better medical care is the idea of peer review. This concept suggests that the medical profession in general is suspect and that someone must always peer over the shoulder to see what is going on so that rules and regulations may be applied to make sure the doctor is conforming to edicts from the hands of those advocating Government control.

### **Changes Since Student Days**

In my student days I thought that when a student graduated from Medical School he was recognized as an honorable person, a pattern of his professors, who could be depended upon to do the very best he could for his patient with what he had to do with. Now, according to propaganda and the news media, the doctor in so many instances is sort of a fake, hungry for money, ambitious for status, performing needless surgery and, in fact, guilty

of malpractice in so many instances that his activities and prescriptions must be closely supervised and regulated. Recent propaganda statements have charged that at least 10,000 Americans die each year as a result of a million unnecessary operations. It is called a national scandal and correction by government action is demanded.

Already there are over 20,000 physicians employed in Federal Medicine and 250 major hospitals in the Federal medical system but a good part of the blame for furthering socialized medicine must fall upon the universities and medical schools where socialist concepts are taught.

To think that doctors would sanction abortion on demand is an indication of how far medical ethics has strayed from its relationship with and dependence upon the Creator of Life in the art of healing. Medical practice, regardless of all the great advances of science and technique, is still an art. Each doctor, if he is to be true to his patient, must fashion, with all the aids of scientific research and knowledge, the appropriate plan of action for each differing and unique patient. Whenever coercion and compulsion enter the picture by government or third party interference, the outcome is certain to be a botch for the individual.

There is no doubt that tremendous events and changes are evolving. Perhaps the battle of Armageddon is approaching, perhaps a financial catastrophe may completely alter our free enterprise economy and our form of government. It is felt, however, that there is over all an esoteric or mystic hand at work and that the eventual outcome will be different from what mortal man alone can devise or anticipate. As Fulton Lewis used to say, "That's the way it looks from here."

What, then, can we do? To borrow from Voltaire again, after buf-



feting around the world and experiencing the horror and vicissitudes of life Candide came to a conclusion. After all, he advised, "We must cultivate our gardens."

## Editorial Notes . . .

**Dental insurance has always been far behind other forms of medical insurance.** Now it seems to have caught on. More than 13 million people are now covered—three times as many as there were five years ago. Benefits paid last year totaled \$173 million. Various plans vary considerably in the extent of coverage.

The "plastic room" which was developed 20 years ago at Notre Dame for the study of germfree animals has been adapted to the care and protection of children whose immunity systems are deficient. Since the use of immunity suppression in transplant operations the plastic cubicle has been used to treat adult patients as well.

During the first nine months of the Economic Stabilization Program physicians' fees increased 1.37% while the Consumer Price Index rose by 2.05%. The Semi-Private Hospital Room Index increased by 3.84%, as compared to 6.62% for the previous eight months.

Sol Spiegelman, of Columbia University Institute of Cancer Research, reports the finding of an enzyme which is common to the mouse cancer virus and to nearly all human leukemia patients. The enzyme, reverse transcriptase, has been found in patients with Hodgkin's disease, sarcomas and breast cancer, also. This may provide a lead for finding ways to destroy tumor cells selectively.

**The size of the typical prescription has increased more than the average prescription price; today it is one-third larger than the average in the early sixties.** Adjusted for size, the average 1971 prescription costs \$3.71, down from \$3.83 in 1961. The larger scrips, especially for those with chronic problems, are economical—fewer visits to the doctor, fewer trips to the pharmacy. The price of drugs is practically stable as compared to inflation of almost everything else. The "drug price index" was 105.5 in 1961, 100 in 1967, 99.4 in 1968 and 102.3 in 1971.

**A new group was formed recently—"The Action Committee for Childhood Immunizations."** Its purpose is to make the public more aware of the increasing incidence of childhood diseases that once were thought to be conquered. No research for vaccines is necessary. The vaccines are available. Not enough people use them. Epidemics will develop unless children are immunized.—William Schaffner, M.D., Box 12296, Nashville, Tenn. 37212, is chairman of the committee.

**The mobile x-ray unit for case finding in the tuberculosis control program is being phased out.** The modern treatment for pulmonary tuberculosis has not eliminated the disease but it has made it so rare that other screening measures are preferable. The fact that the mobile x-ray unit involves high levels of ionizing radiation is one factor which favors its dismissal.

**G. D. Searle Co. has been investigating the level of health awareness in the general public and finds that it is low—much too low.** As a result, Searle Educational Systems has devised an eight-part program called "Project Health" for the use of industry in sponsoring health awareness programs. The goal is to in-

struct the majority of people who can name only one or usually none of the early signs of malignancy. And also those who ignore, for themselves, the dangers of heart disease, alcoholism, drug abuse, obesity, and careless driving.

**A new prostaglandin analog has been isolated.** It is up to 50 times more potent than its natural relative in inhibiting gastric secretion in animal tests. Research continues to determine its applicability for the treatment of peptic ulceration. Dr. Andre Robert, an Upjohn scientist, expects the drug to go through several years' trials before its potential can be defined.

**Marijuana at high dose levels—the equivalent of 6 to 9 cigarettes—produces significant changes in the electrical activity of the brain, a VA researcher has found.** This indicates that marijuana, unlike alcohol or barbiturates, might have an over-all effect on the central nervous system. The observed change is a slowing of the alpha waves.

**The National Association of Retail Druggists has just conducted a year-long study of the proposal to change antisubstitution laws.** The conclusion is: "We find no evidence that unilateral authority to substitute brands on physicians' or dentists' prescriptions would contribute to the public welfare, the pharmacists' professional status, or his economic well-being."

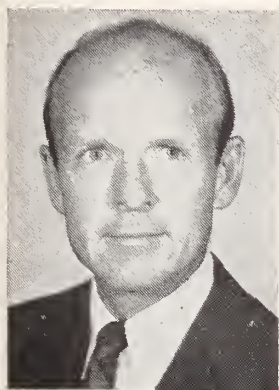
**The Pharmaceutical Manufacturers Association and the Bureau of Narcotics and Dangerous Drugs have established a working committee on industry self-regulation for prevention of drug diversion from legitimate manufacturers.** Guidelines have been developed. The two organizations will meet regularly in the future to implement the control program.



# Medical Manpower in Indiana\*

RAYMOND H. MURRAY, M.D.  
Indianapolis\*\*

THE controversy about the shortage of physicians is complex because it involves more than the number of doctors. The rise of specialization, the uneven geographic distribution of doctors and the increased complexity involved in delivering modern health care also play a part, and, perhaps of greatest importance, is the greatly increased demand for health services made by the public.



National statistics show the number of doctors in the United States has risen strikingly over the past 30 years, even outstripping the population growth. The doctor population ratio is greater now (165/100,000) than it was in 1940 (140/100,000). But more than offsetting this, from the viewpoint of the patient, is the sharp fall-off in the number of primary care physicians. The rise in internists and pediatricians over this period has failed to keep pace with the decrease in the ranks of the general practitioners; they accounted for over 80% of the country's doctors in 1930, but less than 25%

in 1970. The shortage of primary care physicians is keenly felt in rural regions where the loss of general practitioners is most apparent. The future of these areas is cause for great concern, since the general practitioners remaining are leaving practice at an alarming rate because of death, retirement, and widespread dissatisfaction with the rigors of rural practice. On the other hand, the number of specialists has increased rapidly in recent years and certain specialties seem to have over-produced; many feel, for instance, that we have a surplus of general surgeons.

Another major factor in the unavailability of medical care is the burden of work on primary care physicians which has increased so greatly over the past generation. This is due, in part, to the success of basic and clinical research which has provided the scientific breakthroughs responsible for so many new tests and treatments. Yet an even more important factor is the escalating demand for health services made by patients; this is attributable mainly to six factors:

- 1) Medicine's dramatic success in some areas has created expectations of success in all aspects of health care.
- 2) A more educated public uses more health services.
- 3) Our health education programs urging the public to see their doctors for any and everything have been very successful.
- 4) Money is more plentiful.
- 5) Widespread health insurance coverage with broader bene-

fits is generally available.

- 6) The growing sense that health care is a right for all has given birth to several new federal health programs, such as Medicare and Medicaid.

Indiana shares all of these manpower problems. Last year Indiana ranked 38th of 50 states in the doctor/population ratio; we had one third fewer physicians than the national average. While we do relatively well in regard to the *percentage* of general practitioners, our actual general practitioner/population ratio is low. Also important is the fact that the number of specialists practicing in the state is especially low.

Everyone is aware of the critical nature of medical manpower in Indiana's rural regions. Because the severity of this problem has never been accurately documented, the Department of Community Health Sciences and the Regenstrief Institute are carrying out a comprehensive survey of health needs in rural Indiana. These studies should be completed in late 1972. It is clear from the material that is presently available that these regions are already in serious trouble. Special effort on the part of all concerned with health care delivery in our state must be directed to this problem.

Our inner-city areas are also doctor-short. While a number of innovative projects have addressed this problem, such as the Metropolitan Health Council's Neighborhood Health Center program in Indianapolis, there is no general solution in sight. Gary's medical care system has been severely strained by its

\*Modified from an address to the Indiana Advisory Comprehensive Health Planning Council April 5, 1972.

\*\*Chairman, Department of Community Health Sciences, Indiana University School of Medicine; Director, Regenstrief Institute for Health Care.



acute social problems, such as mammoth unemployment and racial stresses. There is every reason to expect this city's medical system will be in critical trouble in a few years unless drastic action is taken.

### **Many Visits for Trivial Problems**

Of particular importance to our busy Indiana general and family practitioners, internists and pediatricians is the increasing number of office visits for minor and even trivial problems. I carried out an informal survey among 50 general practitioners and internists in Indiana in 1971. They estimated that about 50% of the patients presenting at their offices came for minor problems which the physicians felt didn't really require their care.

What is Indiana doing about these problems? In order to attack the physician shortage at its source the Indiana University School of Medicine has created an innovative approach at all levels of medical education—postgraduate, graduate and undergraduate. The medical school, with the collaboration of the Indiana Regional Medical Program and several regional medical centers, has carried on a comprehensive program to provide practicing physicians of the state with an attractive variety of postgraduate courses tailored to the practitioner's needs.

Working with several strong hospitals throughout Indiana, the medical school helped develop a series of internships and residencies, most of which are directed by part-time or full-time Directors of Medical Education. These programs have been responsible for retaining in Indiana many physicians who would have left. In the past, we lost over 60% of our graduates to other states; now we lose less than 40%.

Most inventive has been its much-copied regionalization of undergraduate medical education. Based on its longstanding success

with the provision of basic science medical education at Bloomington, the medical school extended this program to six other campuses over the past three years. In the fall of 1971, we enrolled 10 first year students at Notre Dame, 12 students at Purdue, 10 each at Ball State and Indiana State Universities, while 200 students were assigned to the Indianapolis campus and 32 were enrolled in the Bloomington program. In 1972 we increased this total to 290 entering students and activated centers for medical education at Evansville and Gary. All these students will receive their second and third years of medical education at the Medical Center at Indianapolis. To assist in providing an excellent clinical education for these large classes, the medical school has worked with hospitals and individual physicians throughout the state to provide an attractive series of clinical electives for our fourth year students. These have proved to be very popular; students have welcomed the opportunity to become involved in private medical practice in non-university settings.

### **Network Television Aids**

To help tie together this complex series of medical education programs, the Medical School has developed an extensive medical television network which has been integrated into the state-wide university television system.

In order to provide graduate training opportunities for an increasing number of our students who are interested in primary care practice, several hospitals in Indiana, with the collaboration of the Indiana Academy of Family Practice, have developed a series of family practice residency training programs. At this time, Indiana has seven programs, located at Indianapolis (Methodist and St. Vincent Hospitals), South Bend (Memorial and St. Joseph's Hospitals), Evans-

ville (St. Mary's Hospital), Muncie (Ball Memorial Hospital) and in Ft. Wayne (where all three community hospitals joined in the venture). Several other hospitals in the state are preparing plans for additional training programs. Of great importance to this movement was the recent appointment of Dr. A. Alan Fischer as Director of the Family Practice Program at the Indiana University School of Medicine.

### **Exciting Health Care Research Underway**

The medical school has also been active in health care research. Its Department of Community Health Sciences and the Regenstrief Institute for Health Care have initiated a series of projects to enhance the efficiency and effectiveness of practicing physicians. We are training Family Nurse Practitioners at the Indianapolis campus and Physician's Assistants at Ft. Wayne, in collaboration with the Ft. Wayne Center for Medical Education, the three community hospitals and the regional campus of Indiana University and Purdue University. With the Department of Electrical Engineering at Purdue University we have embarked on a program to bring the benefits of engineering technology to health care delivery. Currently, we have underway medical-engineering teams which are developing programs for computer-assisted history taking, diagnosis, drug warning systems and record keeping. Other teams are involved with computer interpretation of chromosome smears and x-ray films. We have developed a new tie with the Department of Industrial Engineering at Purdue to bring to medical practice those systems engineering advances which have proved to be so effective in industry and business. Recently, the Department and the Institute have begun efforts to work with two smaller communities (Connersville and Paoli) to create new



kinds of group practices which can bring the benefits of modern medical care and recent health care innovations to our smaller cities and towns.

Two other recent innovations must also be mentioned. Methodist Hospital in Indianapolis, with the Indiana University School of Nursing and the State Board of Health, created a program to train Pediatric

Nurse Associates to assist Indiana's pediatricians and general practitioners in the delivery of well-baby care. Two Columbus physicians, Drs. Robert M. Reid and Richard A. Snapp, founded Medi-Tech Inc. to promote the use of technology in medicine; their computerized medical history system is being used in several doctor's offices and hospitals in Indiana.

I believe it is clear that Indiana is

responding vigorously to its shortage of medical manpower. Early results have been very gratifying, and there is reason to expect that these new programs described above, and others yet to come, can solve our problems. But the solution will take the cooperation of all of us in the health field and the active support of our citizens and our local, state and federal governments.



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## Convention Hears from Dr. John Budd, Cleveland, AMA Trustee

I am really delighted to be with you today and I am honored to be your guest.

It is an equal honor for me to be a representative of the Board of Trustees of the AMA. The purpose of the visitation of the Board, of course, is to improve communications and give us a chance to listen to each other's problems and seek solutions and, of course, of prime importance, to promote unity.

It is vitally important, I think, that physicians do stay together, because in other countries where the government has rather taken over the practice of medicine, they have almost invariably been able to split the profession, the general practitioner versus the specialist, the group practice versus the soloist, the certified versus the uncertified, etc. They were divided and they were conquered.

Of course, as doctors, we get varying appraisals of our skills and talents, depending upon the point of view of the appraiser, whether he be a science writer or a political opportunist, or a comedian, or a plaintiff's lawyer, or a labor leader, etc. We are sometimes revered as benefactors and more often reviled as money grubbing chisellers. We are extolled as super-scientists and condemned, sometimes, as blundering incompetents.

Medicine, sometimes called "the Queen of Professions," has more recently been called—and I am sorry to say, by a doctor—"the last of the pushcart industries," with which I don't agree. To our detractors, I think I would like to make a suggestion that it is a little easier to be critical than to be correct; and I

would like to offer a few thoughts of some things you might say to people when you are called upon to speak up for Medicine.

You might talk about the increasing costs of health care; undeniably, they are increasing, but so are the costs of many other things, such as building a house, or feeding a family, or insuring an automobile or replacing a sink or painting a room or riding in public transportation or running a government or drawing a will, or what have you.

But the fact we should remember is, that the doctor's share of the health care dollar is shrinking quite markedly. In 1966, when the national health bill was \$40 billion dollars, the doctor's share was \$9 billion, which was about 22%. The latest figures I know of, in 1970, when the bill had gone up to \$60 billion, the doctor's share was \$11 billion, which is down to about 19%. And of course in Medicaid, the latest figures I have again are 1970, the bill was \$3 billion and, of that \$3 billion, the physicians took 11%—which would mean that if doctors' fees were entirely abolished, there would be almost two and three quarter billion dollars still in that cost, so reducing or even eliminating doctors' fees would have a slight impact upon the total health care cost.

There are some other charges made about doctor's large earnings and apparently there is a delusion that most doctors practice in small offices with one or two assistants and small overhead and therefore most earnings are profit. Now you all know very well that this is not true, it is a gross miscalculation and I think the public should be in-

formed of that at every opportunity. Of course, we sometimes get some criticism from within the profession, too, and that is particularly aimed at the AMA as well as the state associations, and one of them is that the AMA has failed to protect the doctor's interests and the right to practice and protect him from government intrusion.

This, to a degree, unfortunately is true and unavoidably so. It might have been a lot worse if there were no efforts made to protect us. However, I think that we have not lost the big issue—that would be the federally controlled and federally operated and federally financed complete National Health Insurance service. Those of you who are old enough to remember 1948, when Mr. Truman was elected, will recall that at that time they said that, via the Wagner-Murray-Dingle Bill, within two years there would be a federally administered National Health Service.

Now, a quarter of a century later, it hasn't yet happened and if in the next two years there is a National Health Insurance Bill, I think you can make book on it that it will not be very similar to the Wagner-Murray-Dingle Bill, nor even to the Kennedy-Griffiths Bill. In fact, politicians and commentators and labor leaders and other influence wielders state—or rather I should say—complain, that the AMA has the most powerful lobby in Washington. I think we have a remarkable one considering it is basically composed of four people who are terrifically talented and very dedicated and very hard working, and I think they do a wonderful job.



You might ask—who are the biggest spenders, lobby-wise, in Washington? Maybe you are aware of it and maybe not, but the biggest ones, according to the Congressional Quarterly, is the Common Cause, John Gardner's outfit, which last year spent \$845,000 dollars. Right behind it is the Veterans of World War I, the American Postal Workers Union, AFL-CIO Headquarters and the American Farm Bureau; the AMA is 11th on the list.

Another thing that is a popular topic for critics right now is what is called the maldistribution of physicians. Of course this is a whole subject itself, involving such things as specification, the siphoning off of physicians into education, research, administration, the armed services, etc. Senator Kennedy, just about two weeks ago, speaking to the American Academy of Family Practice said (a direct quote) "hundreds of counties and thousands of communities have no physicians at all." Now what are facts about that?

In the United States there are 3084 counties, 132 of which, indeed, have no medical doctors. However, most of them are extremely sparsely populated; two, for instance in Colorado have respectively 200 and 500 people in them and they comprise an area of 1000 square miles each. *Of these 132 counties without doctors, 50 of them hold less than 2,000 people and in these 132 counties only two tenths of 1% of the population of the United States lives.* These counties are also very short of things like clothing stores, department stores, movie theatres, teachers and, probably, barbers. Probably for a good reason.

Now this is not to equate medical care with these other items but it is unfair to criticize doctors for failing to locate in these communities. Another thing about these 132 counties—36 of them are adjacent to extremely well populated counties

where there are many doctors and sometimes, within a distance of 10 to 15 miles via a federal highway right through the county, there is access to a well populated area with lots of doctors—probably easier to reach than from one side of Indianapolis to the other on a busy traffic day.

Additionally, the presence of osteopathic physicians is largely ignored in talking about these things. I saw something the other day that said eight rural counties in Missouri had no medical doctor. That is true, *but every one of them had at least one osteopathic physician* and, of the 132 counties which have been mentioned as being doctorless, *32 of them had one or more osteopaths.* This is not to say there aren't shortages but rather to restore some perspective to these charges.

Mr. Rashi Fein, who is a rather well known proponent of National Health Insurance and scarcely to be considered an advocate of the AMA's viewpoint, has written a book on the doctor shortage and in it he has said "physician-population ratios are unequal in different parts of the nation." There are a thousand other ratios that might be similarly calculated, yet little energy has been expended to change public policies to alter the geographic distribution of automobiles, movie theatres or refrigerators.

Membership is a lively item right now and one that you are asked about a great deal and I think I might say right here that Indiana is to be congratulated as one of the most recent states to surpass 1971's total AMA membership. Illinois, Nevada and Kentucky, also made the grade about a week ago.

There are 14 others who have more members right now than they had in the last year and there are 17 states which have less than 20 members under last year's figures. Now that is all we need to catch up.

We might take heart, too, over

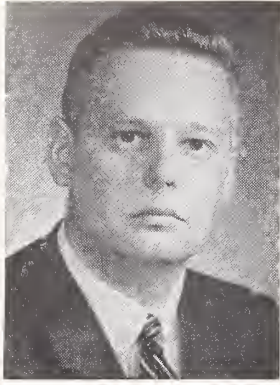
some good news from a recent Harris poll which revealed that, although public respect for leadership in the United States has dropped drastically, there is one and only one vocation in which a majority of Americans are willing to express what they call a great deal of confidence and, not surprisingly, it is doctors. Ranking lowest in public respect are leaders in advertising, trade unions, and mass media.

Similarly there was a poll assaying truthfulness and public respect by the University of Connecticut, (I think it was) and you might be interested to know that TV news reporters had a better reputation for honesty than plumbers by only one notch; one was 11th and the other was 12th. TV repairmen outranked newspapermen 15 to 16; labor union officials were more trusted than politicians—they were 18th versus 19th and final in this list of 20 with the lowest credibility were used car salesmen and at the top of the list, again, were physicians. An Ohio newspaper, I am sorry it wasn't a Cleveland paper, but it was another paper, said this "inasmuch as physicians are first and politicians are next-to-last, it is somewhat paradoxical that politicians are burdening doctors with compulsory services which are financed by taxpayers who have little faith in politicians."

We have much to be proud of and I think we have a big job ahead of us to keep doctors' reputations where they belong, to better public health, and to increase the science and art of medicine. There is need, I would say, for a large central organization to coordinate the efforts of all the smaller groups. There must be national leadership and in my opinion, the group which is capable of doing this job is the AMA and I would recommend it and I would say we can do more together. ◀



# TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

HERE is still time to establish a qualified retirement plan so as to provide yourself with federal and Indiana income tax deductions for the current year for the contributions that you make under the plan. The earnings on your contributions are exempt from income taxation as the earnings are earned, and there are some income tax advantages when the contributions and earnings are withdrawn from the fund at your retirement, either as a lump-sum distribution or as an annuity. If you intend to organize a professional corporation and utilize one of the qualified plans available to corporations, then you should discuss your situation with your lawyer, stockbroker, insurance representative, and banker. But do it now so that you have the opportunity to make a decision before the end of the year.

Do you know what is the last day of 1972 on which a cash method taxpayer may sell corporate stock over the New York or American Stock Exchanges in order to have the gain or loss recognized in 1972?

Since a cash method taxpayer does not report gain until he actually or constructively receives the proceeds from a sale, the answer to the question for gain purposes is affected by the period of time that the stockbroker has, under stock exchange rules, to deliver the cash to the taxpayer. The New York and American Stock Exchanges require the broker to deliver the proceeds within five business days after the sale date. Thus, a taxpayer may sell his corporate stock on or before December 21, 1972,\* and recognize a gain in 1972. If the taxpayer sells his stock after that date, then his gain will be recognized in 1973, unless he requests that his broker accept a cash sale, in which case the sale could be made as late as December 29, 1972, because the broker would be required to deliver the cash to the taxpayer on the date of sale.

If the cash method taxpayer has a potential loss on his stock, he is unaffected by the stock exchange rules concerning cash delivery. I.R.C. section 165 allows a loss deduction in the year that the loss is incurred, regardless when the sale

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\*This date may be changed to an earlier date where, for example, the New York Stock or American Exchanges decided to close on an earlier date than they now plan to.

proceeds are received. Thus, if stock is sold at a loss as late as December 31, 1972, the loss must be recognized in 1972, regardless when the proceeds are delivered to the taxpayer.

However, before you sell any stock at a loss during 1972, remember that if you have an excess of long-term capital losses over your capital gains, then you may lose a deduction for 50% of the excess. Thus, if you can recognize capital gains in order to eliminate the excess long-term capital losses, you generally should do so. Otherwise, consider delaying the recognition of your long-term capital losses until 1972, when you will have another opportunity to recognize some capital gains.

As January approaches, calendar year corporations should consider electing to be taxed under Subchapter S of the 1954 Internal Revenue Code for their taxable years beginning January 1, 1973. However, to do so, the corporations must file their election statements (I.R.S. Form 2553) on or before January 31, 1973. In general, the shareholders also must file their consent statements on or before January 31, 1973. However, because of the recent changes concerning the amount of income on which a shareholder-employee will be taxed, due to a corporation's contribution on his behalf to a qualified retirement plan, it may be wiser not to elect Subchapter S. Further, Subchapter S corporations may want to terminate their Subchapter S elections now.

Have a merry year-end. ◀



# Iron therapy for anemia is almost as old as history itself



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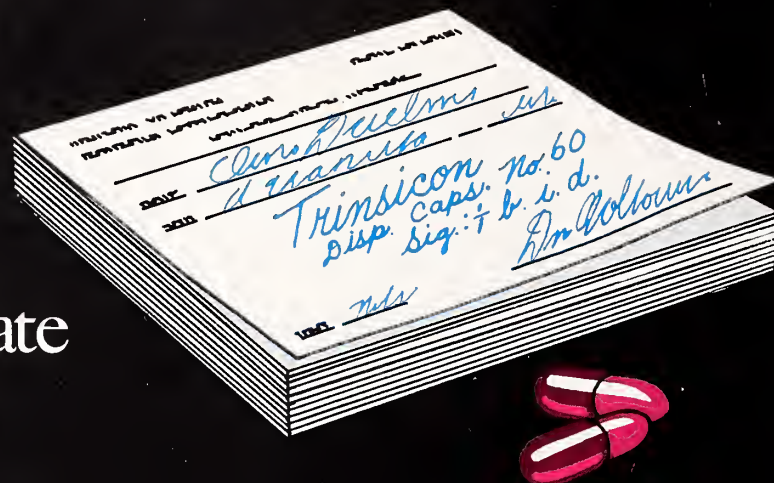
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**Description:** Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly

(containing Intrinsic Factor) . . . . . 240 mg.

Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 7.5 mcg.

(The total vitamin B<sub>12</sub> activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

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Ascorbic Acid (Vitamin C) . . . . . 75 mg.

Folic Acid . . . . . 0.5 mg.

**Indications:** Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

**Vitamin B<sub>12</sub> with Intrinsic Factor**—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B<sub>12</sub> in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B<sub>12</sub> leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B<sub>12</sub>. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B<sub>12</sub> deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B<sub>12</sub> contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B<sub>12</sub>) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

**Folic Acid**—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B<sub>12</sub> deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B<sub>12</sub> interrelationship: (1) B<sub>12</sub> influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B<sub>12</sub> progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B<sub>12</sub>.

**Iron**—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

**Ascorbic Acid**—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

**Contraindications and Precautions:** Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B<sub>12</sub>-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B<sub>12</sub> may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B<sub>12</sub>. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub>, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

**Adverse Reactions:** In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

**Dosage:** One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

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## ABSTRACTS, BOOK REVIEWS

### HEART ATTACK RARENESS IN THYROID-TREATED PATIENTS

Broda Barnes and Charlotte Barnes, Charles C Thomas, Springfield, Ill., 1972; 95 pages, \$7.25.

Professor A. J. Carlson, who was my teacher at the same time that the Barnes were studying at the University of Chicago, is famous for this quip: "If you say 'I don't know,' you flunk. If you say it in three volumes, you become a professor." What a pleasure and rare privilege it is to state flatly that this slim volume says crisply, clearly and incisively in a mere 95 pages what many renowned authors have been struggling to express in lengthy, word beclouded volumes ad nauseam and ad infinitum!

The authors have dedicated a lifetime of effort to just the stated topic. With no fuss or feathers, they demolish—most decisively—many prevalent notions anent cholesterol, diet, relation of decreasing tuberculosis to longevity and to increasing incidence of coronary occlusions; vital role of thyroid action to delaying atherosclerosis; just how simple it is to take basal temperature and so gage thyroid function; but why go on?

This little gem should be **MUST** reading to all of us: from the college professor down to the patient who needs to be told. The printing, binding and paper is of the usual highest standard. Congratulations all around!

ARNOLD LIEBERMAN, M.D.  
New York City

### GROWTH CONTROL IN CELL CULTURES

Ciba Foundation Symposium. Edited by G. E. W. Wostenholme and Julie Knight Churchill, Livingstone, London and Edinburgh—1971; 3 Pounds, 273 pages with numerous charts, tables and the usual references at close of each chapter.

The selected group of experts (including the just announced Nobel laureate) are wrestling here with a problem that has been coming into focus. Just what does regulate cell growth? What is Topo-inhibition? What meaning has the word, *oncogenic virus*? What role do the cell membranes play? Ditto, plasma and nuclear surfaces? Does the multiplicity of phenomena—so closely intertwined—proceed in parallel or is there a serial sequence?

As the whole subject is being scrutinized by ever more research workers, it is not altogether a coincidence that in "Science" for Oct. 6, 1972, Vol. 178, #4056, there is an illuminating article "Carrier-Mediated Ion Transport." Prof. P. Läuger sets up models and explains quite rationally the artificial lipid membrane and the **WHY** of the action of such antibiotics as valinomycin, enniatin B other Macrocyclic Ion carriers. Prof. Läuger's figures are very clear and even an

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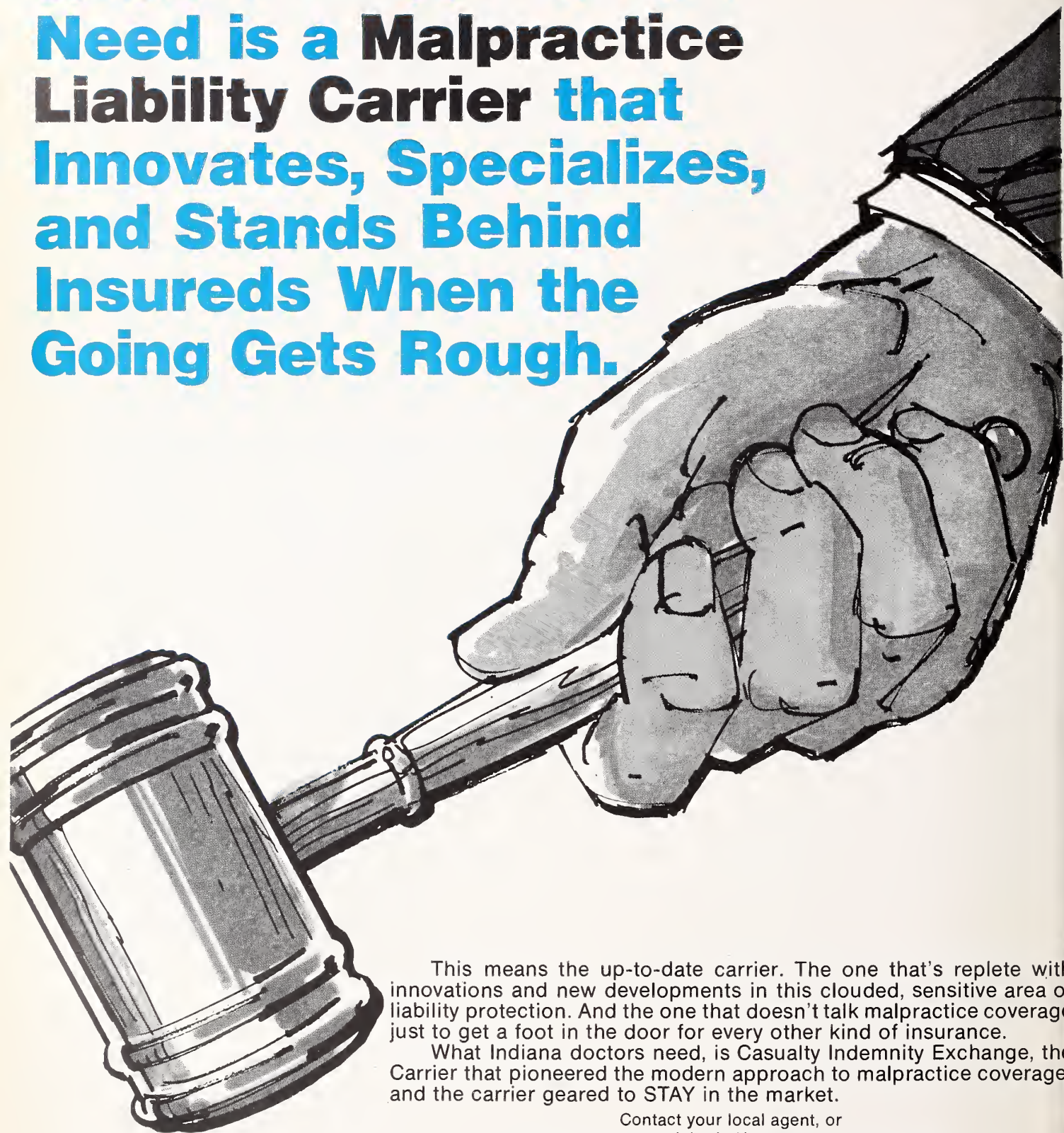
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average M.D. (such as yours truly) can make sense of the thesis being expounded.

As usual, the paper, binding and typography are excellent. I would recommend this symposium for the consideration of those of us who are endeavoring to make sense of the recently burgeoning field that encompasses also the whole question of the WHY of cancers.

ARNOLD LIEBERMAN, M.D.  
New York City

THE TRUTH ABOUT VITAMIN E

Martin Ebon, Bantam Books, New York, July, 1972; 160 pages, \$1.25.

Mankind is forever seeking a cure-all and, in the humoral theory of physiology, it could naturally be assumed that one substance might restore the "balance of the humors." In modern times both cortisone and penicillin have passed through a panacea stage. That Vitamin E or Alpha Tocopherol, which was first isolated in 1922, continues as the chimeric universal preventative is difficult to believe, but such books as this one are written because the exact place of Vitamin E remains uncertain. I can't, for instance, imagine a book entitled, "The Truth About Castor Oil." We all know what that is for!

Let me name a few chapter titles to convey an idea of the author's approach. There is "Keeping Your Blood Young," followed by "Toward A Vigorous Sex Life" and "But Will It Erase My Wrinkles?"

The Appendix contains some factual scientific references and information. This was not written by the author but excerpted from a larger volume on nutrition.

Doctors Evan and Wilfred Shute of Ontario, Canada, are quoted extensively here. They have apparently based their careers on the selling of the idea of Vitamin E as a panacea. Are they right? The AMA Council on Nutrition has taken a negative stand and seems to have gained the ill will of the E-enthusiasts. It is intriguing to speculate on both sides of the question but the answer is not to be found in this book.

I will not mention the statements by Mr. Ebon that I felt were illogical. Why could not he have written a factual account which would approximate the word "truth" as in the title? But he is a salesman and not a scientist and, of course, that is the book's greatest deficiency. If you wish to know, however, what concepts are motivating the health food boom, it could be read with benefit.

The literature on Vitamin E, especially from overseas, continues to accumulate and, for this reason, I want to keep an open mind. Something definitive (as a Surgeon General's Report, let's say) is wanted to settle this controversy.

RODNEY A. MANNION, M.D.  
LaPorte County

Abstracts from Various  
Literature, Prepared by AMA

PROGESTATIONAL AGENTS AND  
BLOOD COAGULATION

I. B. MINK et al. (Roswell Mark Memorial Institute, Buffalo 14203) *Am. J. Obstet. Gynecol.* 113:739-743 (July 15) 1972.

The effects of two types of oral contraceptive medication upon blood coagulability were studied on a double-blind basis in 35 women. A progestin alone induced only minimal changes

Continued

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to have  
and hold onto**





in some procoagulant levels, in contrast to the marked rises which accompanied progestin-estrogen combination therapy.

# CYTOGENETIC DIAGNOSIS OF MALIGNANCY IN EFFUSIONS

W. F. BENEDICT and I. H. PORTER (Albany Medical College, Albany, N.Y. 12208) *Acta Cytol.* 16:304-306 (July-Aug.) 1972.

Cytologic and cytogenetic analyses were done on effusions from 45 patients. Every effusion diagnosed cytologically as containing malignant cells had abnormal chromosome patterns in contrast to effusions in patients with heart failure or cirrhosis. The positive cytogenetic findings of aneuploidy and marker chromosomes are diagnostic of malignancy.

# ALLERGENS RESPONSIBLE FOR HOUSE DUST ALLERGY. PART I.

T. KAWAI et al. (D. G. MARSH, Good Samaritan Hosp., Baltimore 21239) *J. Allergy Clin. Immunol.* 50:117-127 (Aug.) 1972.

Isolated leukocytes donated by 20 highly dust-allergic individuals living in the Baltimore area showed widely different relative sensitivities to dialyzed extracts of the mite *Dermatophagoides pteronyssinus* and a commercial United States house dust sample. There was no significant relationship between sensitivity to dust and mite. Immunodiffusion analysis using hyperimmune rabbit antimite sera showed that the main antigen shared by the mite and dust extracts was a component of human dander used as part of the mite growth medium. Mite components represent only some of the many dust allergens and the most potent mite antigens for rabbits are not the major allergens for man.

# UNUSUAL LABORATORY EXPOSURE TO RABID SKUNK

D. T. CAPPUCCI, Jr., et al. (425 Vicksburg St., San Francisco 94114) *J. Am. Vet. Med. Assoc.* 161:641-642 (Sept. 15) 1972.

A dead striped skunk, *Mephitis mephitis*, was collected and preserved intact for nearly two years at -20 C. A zoologist accidentally cut himself while skinning the carcass for preparation as a museum specimen. Results of subsequent fluorescent rabies antibody and mouse inoculation tests on the skunk brain tissue were positive for rabies virus, and the zoologist underwent postexposure antirabies treatment.

# EFFECT OF METHOD OF OPENING AND CLOSING ABDOMEN ON INCIDENCE OF WOUND BURSTING

R. M. KIRK (Hampstead General Hosp., Haverstock Hill, London) *Lancet* 2:352 (Aug. 19) 1972.

Paramedian incision of the abdomen, displacing the medial edge of the rectus muscle and subsequently closed in layers using continuous sutures of chromicized catgut, was compared with straight-through vertical incisions, closed in one layer using continuous sutures of monofilament nylon. The series, 540 and 327 respectively, were consecutive. The straight-through incision, closed in one layer, proved to be quick and significantly reduced the frequency of burst abdomen.



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## ABSTRACTS, BOOKS

Continued

### PREVENTION OF RH IMMUNIZATION FOLLOWING ABORTION

J. A. GOLDMAN (Tel Aviv Univ. Medical School, Tel Aviv, Israel) and B. ECKERLING *Harefuah* 83:100 (Aug. 1) 1972.

Thirty-four Rh-negative women who were given an injection of 200 $\mu$ g of anti-Rh (D) immunoglobulin within 72 hours of spontaneous or artificial abortion were studied. None of the women developed Rh-antibodies during the first six months after the abortion. In a control group of 58 untreated Rh-negative women who had had spontaneous or artificial abortion, Rh antibodies were found in three (5.2%) during the first six months after the abortion.

### EFFICACY OF PREOPERATIVE ANTIMICROBIAL PREPARATION OF BOWEL

R. L. NICHOLS et al. (Dept of Surgery, Univ. of Illinois, Chicago 60680) *Ann. Surg.* 176:227-232 (Aug.) 1972

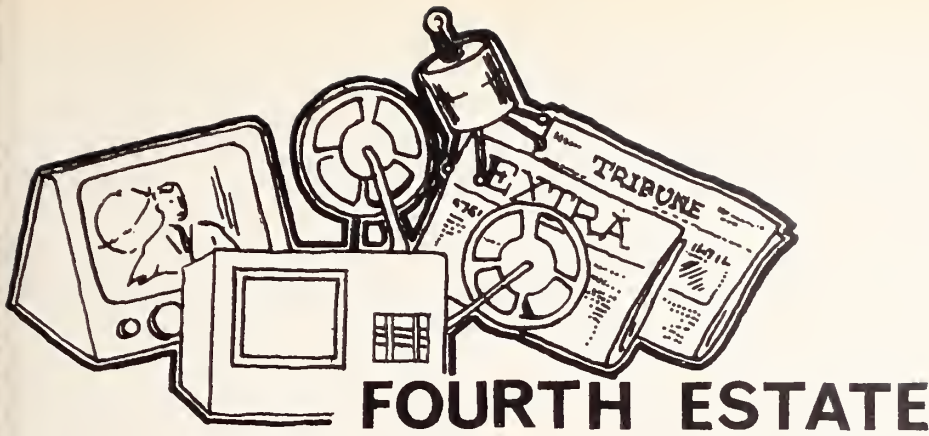
Alterations in intestinal microflora of ileum, intra-abdominal colon, and feces induced by preoperative bowel preparation were studied by direct aspiration at laparotomy. Mechanical preparation without antimicrobials removed gross feces but did not alter concentrations of microorganisms in the lumen of the colon. Administration of kanamycin resulted in decreased concentrations of aerobic organisms but anaerobes, the major constituents of feces, were not affected. Neomycin, alone or in combination with phthalylsulfathiazole, reduced aerobic and facultative bacteria but allowed persistence of anaerobes in approximately half of subjects. Neomycin and erythromycin administered in low doses over 19 hours prior to operation resulted in reduction of aerobes and facultative organisms in all subjects.

### VALSALVA MANEUVER AND CORONARY ARTERIAL BLOOD FLOW VELOCITY

A. BENCHIMOL et al. (Good Samaritan Hosp., Phoenix, Ariz. 85006). *Ann. Intern. Med.* 77:357-360 (Sept.) 1972.

Effects of the Valsalva maneuver on left coronary blood flow velocity were assessed in 15 patients with the Doppler catheter tip flowmeter. Straining against a closed glottis induced a decline of coronary flow velocity that ranged from 14% to 72%, with a mean of 45% for the study group. In seven of eight patients who executed the Valsalva maneuver, twice the maximum decrease of coronary flow velocity was related to the magnitude of mean right atrial pressure rise. In three subjects with heart disease there was an unexpected continuous reduction of coronary flow velocity long into the post-straining period. These adverse consequences of the Valsalva maneuver on coronary blood velocity may account for some cases of "bedpan death."





This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Malpractice Suit Boom

Dr. George M. Saypol, president of the New York County Medical Society, testified last week that 10,000 Americans will file malpractice suits against doctors and hospitals across the country in the coming year. His testimony was given to the Commission on Medical Malpractice, which is investigating the dramatic increase in malpractice suits since the mid-sixties.

Why are patients suing at such a rapidly increasing rate? The breakdown of the traditional long-term relationship between patient and doctor is a major cause. No longer are patients reluctant to sue a doctor since the family physician of long acquaintance has passed from the scene in many communities.

The contingency fee system was another big reason. Under that system, attorneys collect nothing if they lose a case, but share a percentage of the patient's award if they win. However, arbitration has helped to settle half the malpractice suits in New York. That broke the logjam but it did not get the heart of the problem.

Because of the increased lawsuits, premiums range from \$1,811 a year for protection, against \$1.5 million damage judgments to \$6,797 for a doctor who has not been "charged" to \$23,000 a year for one who has been accused. Of course, these premiums are passed on to clients and

form a large part of the cost of medicine today.

Even more important, the claims must be stopped from coming in. Good service, closer patient-doctor relations, greater responsibility on the part of doctors, and patience and forbearance on the part of the patients are needed to halt the ominous boom. — **Seymour Tribune**, Mar. 29, 1972.

## "No Fault" Medical Suits

"No fault" insurance in medical malpractice situations is being seriously studied, as in no-fault insurance in car accidents. The fact that there are pending more than 10,000 malpractice suits against doctors and hospitals, and that it often takes as much as five years to resolve them, is intensifying public interest in the proposal. The litigation costs \$100 million a year, and is increasing at a rate of 10% a year.

There is considerable difference between automobile accidents and medical accidents—whether a medical injury occurred and the result deviated from an expected set of results from like procedures. In an automobile accident, usually one is at fault. In a medical accident, the patient is not at fault.

A 21-man commission is investigating this and other proposals. Dr. Charles A. Hoffman, president-elect of the American Medical Associ-

ation and a commission member, thinks the no fault avenue must be explored. Many legislators are intensely interested.

The opposition to no-fault medical action comes from the bar, as it does from no-fault automobile procedures. Lawyers take medical malpractice cases on a contingent basis, for a large share of the damages. This often runs into six figures. On the other hand, no-fault could speed settlements without legal cost. Canada, where contingent fees are not known, has few malpractice suits.

The commission is not expected to report until after the election, to avoid any effect on the public. It is just as well, because whatever the commission recommends is bound to be highly controversial.—**Pharos-Tribune and Press**, Logansport, Mar. 31, 1972.

## Should They Be Any Different?

If you have been reading The Tribune lately you will have noted that we reported how the New Albany-Floyd County Hospital Board of Directors has begun plans to build an addition to the hospital.

A couple of years ago they paid a substantial sum for a set of plans, but it seems unlikely that they will be used.

It seems that the new addition is not for bed space, since they have



not been particularly flooded with patients.

A few months ago they closed one wing of one floor because they didn't have enough patients to keep it full. This makes sense to us economically.

If they really do need an addition to the hospital for housing records, storage offices and administrative purposes, we have a simple suggestion on how to finance it without having to clobber the taxpayers or the paying patients at the hospital.

Consider the fact that grocers build stores to sell groceries in, mechanics build garages to repair

cars in, and even newspapers have to build buildings to produce newspapers in. The public doesn't build these plants out of taxes, the profit-making business pays for it themselves.

Somehow the two most profitable professions, law and medicine have somehow bamboozled the public into believing that it is the public duty to pay for the factories in which they ply their trades.

Therefore we suggest that the hospital board simply take five per cent of the fees that doctors charge patients who they attend in the hospital and use the money to build

any new structure they want. The new building is of direct benefit to the doctors since without such a structure they would be unable to make the magnificent incomes which they enjoy.

We might add that if you charged attorneys this same 5 per cent to practice in the courtrooms you could build a lot of public buildings as well.

After all, everyone else has to provide the building in which they ply their trade, why should doctors and lawyers be any different? — **The Tribune**, New Albany, Oct. 9, 1972. ◀

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## From The Journal 50 Years Ago

Endocrinology is a science in the making and I am sure it is to be regretted that there is a tendency on the part of many men to decry it as merely a passing fad. Personally, I predict for the future of endocrinology an enormous place in medicine, and I speak of this from the medical side only. The very fact that Dr. McCaskey has been able to present such concrete facts concerning the thyroid is pretty good evidence in itself that with the passing of time and with the study which we will be able to give the relation of the so-called ductless glands, we will have very nearly as definite a statement to make concerning other of the endocrine organs.

The problem at this time of course is the matter of treatment, particularly the treatment of those diseases in which there is hyperfunction of some of the endocrine organs. Hypofunction is being satisfactorily met, especially as regards five or six of the more important endocrine organs. We know exactly what thyroxin will do, and what dessicated thyroid will do within certain limits. Personally, I am enthusiastic about the administration of ovarian substance. I believe in properly selected cases we have in ovarian substance a remedy which has been a God-send to a great many women. The use of pituitary substance I do not know so much about, except of course in obstetrics, where it has a limited field.

I am looking forward with eager anticipation to the further development of the work which McLeod of Toronto and his co-workers have recently done on the pancreas. In the **Boston Medical and Surgical Journal** some three months ago was a letter written to the editor by Joslin, discussing this work and speaking of it in such enthusiastic terms that I could not help but feel, coming from such a conservative man as Joslin, that before many months **insulin**, as McLeod has named this product, might offer the possibility of cure in diabetes, which as we know up to this time has been an utter impossibility. . . .

Edgar Kiser, M.D., Indianapolis, Discussion at Symposium on Endocrinology at the 1922 Annual Meeting of the Indiana State Medical Association, **JISMA**, December 1922.



# Continuing Education for Physicians

## Postgraduate Courses in Indiana—IUSM

### Head and Neck Anatomy and Clinical Otolaryngology March 18-30, 1973

The Department of Otolaryngology announces the 58th Annual Postgraduate Course in Head and Neck Anatomy and Clinical Otolaryngology, to be given March 18 through April 30, 1973. This intensive course correlates didactic anatomy of the head and neck with clinical application to the current practice of Otolaryngology, together with histopathology of the head and neck. The course consists of didactic lectures, cadaver dissections, histopathology laboratory sessions, and clinical lectures in Otolaryngology given by the staff at the Indiana University Medical Center.

This course is offered to Board Eligible and Board Certified otolaryngologists and residents training in this specialty. (IUSM, Indianapolis)

### Current Topics in Internal Medicine April 5-6, 1973

The purpose of this course is to review selected topics from the viewpoint of the practicing internist (or the general physician with a major interest in internal medicine). Recognizing that it would be unrealistic to attempt a survey of all areas of internal medicine in a single two-day course, several subspecialty areas will be chosen annually for particular emphasis. Emphasis will be varied from year to year, so that a regular course participant may expect to review most major areas within any three-year period. Active participation on the part of those attending the course will be encouraged through

the use of question periods at the end of each talk, solicitation of questions for the panel discussions, and an opportunity to participate in one or more "Meet-the-Professor" sessions. Course notes will be provided. (Convention—Exposition Center, Indianapolis)

Additional courses have been announced, as follows:

#### INDIANAPOLIS

- Jan. 17-18** Coronary Care Concepts and Practices, Dr. Suzanne Knoebel, director (Marion County General Hospital)
- Feb. 14** Second Fred H. Priebe Memorial Symposium on Arthritis, Drs. Anthony Ridolfo and Edward Gabovich (Convention-Exposition Center)
- May 2-3** ECG-Arrhythmias and QRS, Dr. Charles Fisch (IUSM)
- May 8-9** Eighth Annual Child Care Conference, Dr. Morris Green, (Stouffer's Indianapolis Inn)
- May 16-18** Advances in Pediatric Radiology, Dr. Eugene Klatte (IUSM)
- May 23** Office Orthopaedics, Dr. David Hadley (IUSM)
- June 5-7** Review for Family Practice Board Examination—Part I, Dr. A. Alan Fischer (Convention-Exposition Center)
- July 10-12** Review for Family Practice Board Examination—Part II, Dr. Fischer (Atkinson Hotel)



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# *The Woman's Auxiliary*

## REPORTS TO ISMA

Early in October, the annual Fall Conference of state presidents, presidents-elect, national officers and chairmen of the Woman's Auxiliary to the AMA was held in Chicago. The role of volunteers in nutrition service, safety on the streets, and an AMPAC dinner featuring a mock election were highlights of the conference.



The conference opened on a Sunday evening with regional dinners, followed by a preview of films which are available for showing to groups through the Woman's Auxiliary.

The keynote speaker, William Purkey, Ed.D., from the University of Florida, discussed the importance of valuing self, before we can reach out to others; that we cannot give what we do not have. He told us there is no way to be a zero—that we are either putting something into life or taking something out.

At luncheon, Dr. John Kernodle, chairman of the AMA board of trustees, presented three challenges to the auxiliary; organizing membership campaigns, strengthening the AMA's hand in Washington, and expanding health education programs.

Following the luncheon, we heard speakers giving tips on safety on the streets, telling of volunteers in nutrition services and our own Dr. Norman Booher, a member of the AMA council on Voluntary Health Agencies, who explained the goals of the council and asked the auxiliary to work on forming a liaison committee, as we have done here in Indiana.

The next event on the month's calendar was the ISMA convention in Indianapolis. The report of the Woman's Auxiliary was delivered to the House of Delegates on Sunday. Tuesday morning of that week, a state auxiliary board meeting—open to all doctors' wives—was held.

At the conclusion of this convention, I flew to Kansas City for the North Central Workshop. This is a two-day learning and sharing experience. We have the opportunity to exchange ideas with other states—as well as to receive answers to questions that we might have. In comparing experiences, I find that Indiana rates high in organization and programming. We can all be proud of the Indiana Auxiliary members and their accomplishments.

We hope you will remember to support the Auxiliary projects for AMA-ERF, such as the lovely Christmas cards and elegant watches for sale—as well as memorials and donations. As you no doubt know, this money is used for the support of medical schools and for the student loan guarantee fund. Contributions to the funds are distributed annually. Money marked for a particular school is presented to the school plus an equal share of undesignated funds. Money contributed to the Loan Guarantee Fund is held as a guarantee for repayment of loans made to medical students. Each dollar contributed to the fund puts another \$12.50 to work in loans made by a commercial bank. The AMA-ERF is a purely voluntary fund.

I'd like to express my greetings for the holidays, with the hope that we may all share in the joys of the holiday season.

“May all men in prayer unite and be as one with God again,

And sing the song of the blest night,  
Sweet peace on earth, good will to men.”

Robert I. Burton

*Marjorie Smith*





**Liability for Blood Transfusion Violating Religious Beliefs**—If hospital and physicians gave a blood transfusion in violation of a patient's religious convictions, they would be liable for violation of the patient's constitutional rights, a federal trial court in Illinois ruled. On the other hand, a conservator appointed by a probate court magistrate for the purpose of authorizing the blood transfusion shares the immunity from suit possessed by the magistrate who appointed him.

A 20-year-old married man was taken to the hospital after suffering injuries in an accident. He informed the physicians that his religious convictions precluded his accepting needed blood transfusions.

The physicians were unable to persuade members of the patient's family, including his wife, brother, sister and parents, that he should have a transfusion. The patient and his wife signed a form releasing the physicians from liability in performing surgery without use of blood transfusions.

Four hours after the patient's arrival at the hospital he lost consciousness. The physicians and hospital then allegedly conspired to have the probate court declare the patient incompetent as a minor and to appoint a conservator for the purpose of authorizing a transfusion. Under Illinois law, an incompetent is defined as a person incapable of managing his person because of physical incapacity.

The magistrate declared the patient an incompetent and appointed a conservator for the purpose of consenting to surgery, blood transfusion, medicine and drugs. After receiving authorization from the conservator, the hospital directed the physicians to give a transfusion, knowing that such act violated the patient's religious convictions.

After the patient died, his wife, as administrator of his estate, brought action against the conservator, the hospital and the physicians, charging violations of the First Amendment guarantee of freedom of religion. She also asserted that they conspired to deny the patient and his family the notice and hearing required by statute to determine whether he was a neglected minor or whether the transfusion was a medical necessity.

Before the state may restrict a person's religious beliefs, it must show it is acting to prevent grave and immediate danger to interests it may lawfully protect, the court said. A mere rational basis was not sufficient for the state to restrict the free exercise of religion.

The court said a state-appointed conservator's ordering of a transfusion in violation of a patient's religious beliefs would violate the First Amendment's freedom of exercise clause if no substantial state interest could be shown. However, the court upheld the conservator's contention that he was not liable for his actions because of the doctrine

of judicial immunity, even if he did deprive the patient of constitutionally protected rights.

The conservator was appointed with specific directions as to his course of conduct and was given no discretion. Granting his motion to dismiss, the court said the conservator was entitled to the same immunity as the magistrate who appointed him.

The hospital and physicians contended that even if they denied the patient a constitutional right, they did not do so under color of state law and thus were not liable for damages under the Civil Rights Act. The patient's wife contended that, because of state and federal tax exemptions and receipt of state and federal funds, the hospital should be construed as being an arm of the state for purposes of the First Amendment and the Civil Rights Act.

Reviewing previous decisions, the court noted that when a party was licensed by the state and subject to regulations as to its operations, the actions of that party were under color of state law. Therefore, the court concluded that any action taken by the hospital to deprive a patient of his civil rights must be deemed as state action and the hospital was liable under the Civil Rights Act for any constitutionally prohibited actions.

The physicians contended that resolution of the issue of state action with regard to the hospital was immaterial as to them. The court held that they acted as agents of the hospital, which was charged with state action, and therefore must take on the responsibilities of the hospital, which was incapable of acting except through the use of agents.

Accordingly, the court denied the hospital's and physicians' motions to dismiss the case. The suit against the hospital and the physicians was therefore eligible for trial.—*Holmes v. Silver Cross Hospital of Joliet*,



*Illinois*, 340 F. Supp. 125 (D.C., Ill., Jan. 17, 1972).

**Damages Awarded for Negligence in Taking Pap Smear**—A patient who suffered invasive cancer, allegedly as a result of delay in diagnosis because of inadequacy of a Pap smear, was awarded \$160,000 by a California jury.

The patient, a 51-year-old woman, entered a clinic with complaints of pain in the lower right abdomen. A physician took a Pap smear and sent it to a laboratory for analysis. The laboratory reported negative findings.

The patient was later found to have invasive cancer. After treatment with cobalt, she had a 40% chance of surviving for five years.

In an action for malpractice against the laboratory and the clinic, the patient contended that the physician had been negligent in taking an inadequate specimen and in not taking a second one. She further contended that the laboratory was negligent in not reporting to the physician that the specimen was inadequate and in not rejecting it instead of just reporting it negative. She said she had cancer of the cervix when the Pap smear was done and that a hysterectomy could have stopped the spread of cancer if it had been discovered.

The laboratory and the clinic said that acceptable standards of practice had been followed. The physician said the smear was properly taken but that the test was not 100% accurate. The jury brought in a unanimous verdict of \$160,000 against the clinic only. The clinic's motion for a new trial was denied.—*Cornell v. Clinical Laboratories* (Cal. Super. Ct., Los Angeles Co., Docket No. NCC 3792, June 29, 1971).

**Discrimination Against Male Nurse**—A hospital that refused permission for a male nurse to work for female patients violated the Civil

Rights Act of 1964, a federal trial court in the District of Columbia ruled.

A professional nurses' registry assigned nurses to jobs as it received requests from hospitals or individuals. Such assignments were made in a nondiscriminatory fashion.

Requests for nurses of a certain sex, race, religion or national origin were not honored, but nurses were assigned on a first-come, first-serve basis. If a patient rejected the assigned nurse when the nurse arrived, the patient was required to pay the nurse for services for that day.

On two occasions, the male nurse was assigned to care for female patients in the hospital. When he appeared on the hospital floor, and before the patients had an opportunity to accept or reject his services, hospital staff nurses informed him that he could not work for the respective patients because he was a male. Since he was rejected by the hospital nurses, rather than by the patients, the nurse was unable to receive payment that he would have received if he had been rejected by the patients themselves.

The male nurse complained to the Council on Human Rights, and charges of sex discrimination were filed with the Equal Opportunity Commission. The Commission was unsuccessful in attempts at voluntary conciliation and issued the nurse a notice of his right to sue.

The court agreed with the Commission's finding that there was reasonable cause to believe that the hospital had violated the Civil Rights Act. Granting summary judgment in favor of the male nurse, the court said the nurses' registry was created to prevent discrimination and that the hospital should not be permitted to circumvent the safeguards against such discrimination.—*Wilson v. Sibley Memorial Hospital*, 340 F. Supp. 686 (D.C., D.C., April 3, 1972).

**Damages Denied in Failure to Diagnose Early Cancer**—A patient who brought action for malpractice against a physician who allegedly failed to diagnose cancer at an early stage was denied recovery of damages by a California jury.

The patient, a 45-year-old man, contended that he had a lump in the groin in 1966, which was enlarged by 1967. He said the physician did not perform a biopsy. By 1970 he had widespread Hodgkin's disease.

The physician contended that a lump in the groin was not a sign of cancer. He said the lump was small and did not enlarge from 1966 to 1967. The patient's cancer was arrested, but live nodes recurred.—*DeMarco v. Hanfling* (Cal. Super. Ct., San Mateo Co., Docket No. 152125, Jan. 14, 1972).

**Quadriplegic Awarded Damages Against Medical Group**—A patient who suffered quadriplegia, allegedly as a result of being sent home from a hospital after negligent examination by a physician, was awarded \$1,410,700 by a California jury. The award was handed down against a medical group, and not against the hospital.

The patient, a 19-year-old youth, went to a hospital about six hours after being involved in a fight. A physician examined him, said he had been drinking, and sent him home. The next day he was taken to a county hospital, where a fracture was found at C-6-7, with injury to the spinal cord.

The patient brought action against the first hospital and a medical group, contending that the physician failed to examine him properly. He said there was no spinal cord involvement when he went to the hospital but that the ride home in his parents' automobile resulted in such injury. At the time of trial he was a quadriplegic and had amnesia.

The hospital and medical group contended that the patient had the



spinal injury when he arrived at the hospital. They denied the drinking allegation and said that the patient was told to remain at the hospital while a county ambulance was called. They said his parents picked him up and took him home before the ambulance arrived. They also pointed out that the patient had made no claim for two years.

After a 16-day trial, the jury awarded the patient \$1,410,700 against the medical group only. A motion by the hospital and medical group for a new trial was denied, and an appeal was filed.—*Williams v. Bon Air Hospital* (Cal. Super. Ct., Los Angeles Co., Docket No. 979409, Feb. 4, 1972).

**Physician's False Claims for Medicare**—A physician's conviction for filing claims for payment under Medicare for house calls he did not make was upheld by a federal appellate court.

After a jury trial, the physician was convicted on five counts of knowingly falsifying material facts by filing claims for payment under Medicare for house calls he did not make. At the trial, proof indicated that the physician did not make the house calls for which he requested payment. There was testimony that his nurse made the calls and that a nurse signed his name to the requests for payment without his knowledge. The jury apparently rejected the physician's defense that

he did not authorize the filing of the claims.

On appeal, the physician contended there was no proof that he had knowledge that false claims were made with respect to Medicare-covered services. However, the court held there was ample evidence to permit the jury to find that he had knowledge that the claims were false and that he authorized their filing. Affirming the judgment of the trial court, the court further said the instruction to the jury that the physician could be convicted if he willfully authorized another person to submit a false request for payment for him was correct.—*U.S. v. Blazewicz*, 459 F. 2d 442 (C-A-6, May 10, 1972).

INDIANA STATE BOARD OF HEALTH  
MONTHLY REPORT — October 1972

Disease	Oct. 1972	Sept. 1972	Aug. 1972	Oct. 1971	Oct, 1970
Animal Bites	712	1400	1263	920	908
Chickenpox	100	51	57	174	109
Conjunctivitis	162	207	176	124	173
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	23	34	18	14	36
Gonorrhea	671	1289	907	767	817
Impetigo	199	316	174	218	326
Infectious Hepatitis	37	72	39	43	42
Infectious Mononucleosis	100	211	40	109	117
Influenza	2584	2840	1138	1391	1176
Measles					
Rubeola	32	13	16	15	1
Rubella	22	33	33	40	70
Meningococcic Meningitis	1	0	0	4	1
Meningitis, Other	3	2	1	1	3
Mumps	27	32	35	92	117
Pertussis (Whooping Cough)	0	32	60	0	23
Pneumonia	361	352	205	262	379
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1056	870	672	662	715
Syphilis					
Primary and Secondary	26	22	48	27	36
All Other Syphilis	73	89	83	83	139
Tinea Capitis	12	8	6	0	6
Tuberculosis (Active)	66	86	53	61	102





## New Pamphlet on Pregnancy Issued

"Pregnancy and You" is the title of the latest Public Affairs Pamphlet. It is written by Aline B. Auerbach and Helene S. Arnstein to be read by the patient. It explains the physical, mental and emotional changes and reassures the patient about normal changes. Pamphlet number is 482. It sells for 35 cents per copy. Write Public Affairs Committee, 381 Park Avenue South, New York City 10016.

## Dr. Jesseph Receives ACS Plaque

Dr. John E. Jesseph, Indianapolis, chairman of the Department of Surgery, I.U. School of Medicine received a commemorative plaque at the recent Clinical Congress of the American College of Surgeons for his work in authoring a teaching film on "Pancreatoduodenectomy for Ampullary Tumor". The motion picture was produced by a surgical film team from Davis & Geck.

## Questionnaire

Commission on Sports and Medicine  
Indiana State Medical Association

Are you now active in sports medicine?  
Yes \_\_\_ No \_\_\_

If yes: County \_\_\_\_\_  
School \_\_\_\_\_  
Sport or Team \_\_\_\_\_

If no: Are you or would you be interested in sports  
medicine? Yes \_\_\_ No \_\_\_

Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Your cooperation in answering is highly valued as  
we are trying to formulate a state directory of  
physicians active or willing to be active in sports  
medicine.

Thank you,  
ISMA  
Committee on Sports Medicine

(Please clip and return to Indiana State Medical Association,  
3935 N. Meridian Street, Indianapolis 46208)

## Deadline Extended by FDA

The demand for childproof safety closure containers has been so large that manufacturers have not been able to produce a sufficient supply to allow the drug industry to comply with the original FDA deadline. The FDA has extended the deadline to January 22. Meanwhile, pharmacists are required to use the safety closures if they are available.

## Chest Physicians Name Two Fellows

Drs. Robert D. Chaney, Marion, and William S. Mullican, Evansville, were inducted as Fellows of the American College of Chest Physicians at the recent annual Scientific Assembly in Denver.

## Three New Fire Prevention Texts

The National Fire Protection Association announces three updated revisions of fire-prevention texts especially of interest for hospitals. "Standard for the Use of Inhalation Anesthetics (Flammable and Nonflammable)" at \$1.75, "Safety Standard for Hospital Laboratories" at \$1.00, and "Standard for Hypobaric Facilities" at \$1.25 are for sale by the Association. The address is 60 Batterymarch St., Boston 02110.

## Dr. Lester Bibler Delegate

Doctor and Mrs. Lester D. Bibler attended the Fifth World Conference on General Practice at Melbourne, Australia, in October.

Doctor Bibler was a delegate representing the American Academy of Family Practice.

## Fort Wayne Visiting Professorship Schedule for 1973 Announced

The Visiting Professorship Program at IUSM-Fort Wayne will include the following:

### Parkview Hospital

- Jan. 5. "Medical Complications of Drug Abuse," Dr. Walter J. Daly
- Feb. 2, "Exciting New Ideas in the Radiation Therapy Treatment of Malignant Tumors," Dr. Ned B. Hornback
- Mar. 2, "Exciting New Ideas in the Radiation Therapy of Malignant Tumors," Dr. G. Paul DeRosa
- Apr. 6, "Adrenal Disease—New Refinements in Diagnoses of Operable Adrenal Lesions and Advancements in Pharmacologic Management," Dr. Joseph P. Donohue

### St. Joseph Hospital

- May 9, "Arrhythmias—1973," Dr. Douglas P. Zipes
- June 6, "Burn Treatment," Dr. James E. Bennett

The programs will begin at 10:30 with patient presentation followed by informal luncheon and the speaker's presentation.

## Michigan Sets Epilepsy Program

The Epilepsy Center of Michigan will conduct its 25th Anniversary Program at the David Whitney House in Detroit on March 16 and 17. For complete information and program details write the Center at 10 Peterboro, Detroit 48201.



## Dr. Joe Dukes Named President-Elect



Dr. Joe Dukes, Dugger, was chosen president-elect of the Indiana State Medical Association at the 123rd annual meeting of the association in October. Doctor Dukes practices medicine with his wife, Dr. Betty Dukes. They have three sons, Michael and Russell, who are both physicians, and Robert, who is doing postgraduate studies at Indiana University.

A native of Dugger, Doctor Dukes is a graduate of the Indiana University School of Medicine with the class of 1943 and was an intern and resident at Marion County General Hospital.

From 1945 to 1947 Doctor Dukes served with the U. S. Army Medical Corps, attaining the rank of Captain.

Active in many community projects, Doctor Dukes is also Sullivan County Health Officer and chief of medicine of Mary Sherman Hospital at Sullivan. He is on the Executive Committee of the Indiana Blue Shield Plan.

He has served as chairman of the Board of Trustees of the Indiana State Medical Association and as Second District Trustee.

## Medical Assistants Pass In Record Numbers

A record number of medical assistants passed the 1972 certification examination conducted by the American Association of Medical Assistants. Five of the successful candidates are from Indiana. Lulu May Carney of LaGrange, Terry Lynn Hentz of Terre Haute and Sondra Cook Wright of Pierceton passed the clinical examination. Phyllis L. Jones of Fort Wayne and Luanne Tuttle of Fort Wayne passed the administration examination.

## Waiting Room Bulleting Offered

The Indiana State Medical Association's Commission on Public Information is offering to ISMA members a "Question and Answer" bulletin for display in their waiting rooms.

- Subjects covered will include health messages and physician's attitudes in socio-economic matters
- Bulletin will be sent every three months to the first 1,000 members requesting the service.
- There is no charge.

If you are interested in receiving the bulletin, fill out the form below and mail to ISMA headquarters, 3935 North Meridian, Indianapolis 46208.

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# FUTURE MEETINGS, SEMINARS, COURSES

## Nuclear Medicine Meet Set

A Conference on Nuclear Medicine will be conducted for general practitioners, surgeons, internists and pediatricians at Petoskey, Mich., February 7 to 9, 1973. The meeting is sponsored by the Hackley Hospital of Muskegon and the Central Chapter of the Society of Nuclear Medicine. The purpose of the Conference is to instruct practicing physicians in the use of nuclear technics in diagnosis. The registration fee has not been set, but will probably be in the range from \$35 to \$45. For further information, write James C. Carlson, M. S., Nuclear Medicine Department, Hackley Hospital, Muskegon, Mich. 49770.

## Offers Course in Laryngology And Bronchoesophagology

A continuing education course in Laryngology and Bronchoesophagology will be conducted by the Abraham Lincoln School of Medicine in Chicago March 5 to 10, 1973. Interested physicians should write to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago 60612.

## Course Announced at Mobile

A practical course in the technic of intradermal provocative food testing and food injection therapy will be offered March 10 and 11, 1973, at the Admiral Semmes Hotel, Mobile, Alabama. Registration fee is \$125, which includes one dinner and two luncheons. To register send name and money to Dr. Joseph B. Miller, 3 Office Park, Suite 110, Mobile Ala. 36609.

## Neurotology Course Offered

A continuing education course in Neurotology will be conducted by the Abraham Lincoln School of Medicine in Chicago on March 26 through 29, 1973. Enrollment is limited to 12. For application forms, write to the Department of Otolaryngology, 1855 W. Taylor St., Chicago 60612.

## Fractures, Other Injuries, to Be Caribbean Cruise Course Subject

The Tulane University Eighth Annual Postgraduate Cruise Course to the Caribbean will be devoted to Fractures and Other Injuries. The 12-day cruise will include lectures and audio-visual programs suitable for all physicians but especially for general surgeons, general practitioners, and orthopedic surgeons. The course is directed by Dr. Jack W. Wickstrom, Chairman of Orthopaedic Surgery at Tulane. Dr. Sam W. Banks is Cruise Course Consultant. Sailing from Port Everglades, Florida, on February 20, on the T-S Hanseatic. Write Allen Travel Service, 565 Fifth Ave., New York City 10017.

## Hand Surgery Colorado Subject

"Surgery of the Hand" will be the subject of a four-day postgraduate course conducted by the University of Colorado School of Medicine at Denver from February 21 to 24. For further information write Office of Continuing Education, 4200 E. Ninth Ave., Denver 80220.

## ACS to Hold First Annual Four-Day Meeting in NYC

The American College of Surgeons is initiating a new type of postgraduate course which will be conducted separately from the College's Annual and Sectional Meetings. The first of these will be in New York from April 1 to 4. Four courses will be given the first two days and four more the last two days. The subjects will be Cancer, Shock, Gastrointestinal Surgery and Pediatric Surgery on April 1 and 2. On April 3 and 4 the subjects will be Fluids and Electrolytes, Trauma, Peripheral Vascular Disease, and Endocrine Surgery. Physicians who are not Fellows of the College will pay \$50 registration fee and \$35 for each course. Fellows, members of the candidate group, and surgical residents are exempt from the registration fee but will pay \$35 for each course. Write S. Frank Arado, 55 E. Erie St., Chicago 60611.

## Cleveland Clinic Schedule Given

Postgraduate courses to be given at the Cleveland Clinic within the next few months have been announced, as follows:

Managing the Complicated Surgical Patient, January 17 and 18, 1973

Medical Progress for the Family Physician, January 31 and February 1, 1973

Drugs and Treatment Techniques in Angiography, February 7 and 8, 1973

Pharmacology and Clinical Effectiveness of Anti-inflammatory Drugs, February 21 and 22, 1973

Sports Medicine, February 28 and March 1, 1973

Medical Progress and Its Relationship to Dentistry, March 7 and 8, 1973

Advances in Urology, March 14 and 15, 1973

Hodgkins Disease, Leukemia and Lymphoma, March 21 and 22, 1973

Treatment of Neurological Diseases, March 28 and 29, 1973

Current Topics in Clinical Microbiology, April 4 and 5, 1973

Orthopaedic Surgery, April 11 and 12, 1973

Peripheral Vascular Disease, April 25 and 26, 1973

Organization and Administration in Anesthesiology, May 5 and 6, 1973

Advances in Dermatology, May 9 and 10, 1973



## Continuing Education Courses Scheduled by U of Colorado

The University of Colorado School of Medicine's Office of Continuing Medical Education, Denver, has announced the following calendar of courses for 1973:

Colorado Academy of Family Physicians' Annual Sunday Symposium, Jan. 21  
Nineteenth Annual General Practice Review, Jan. 22-27 and March 5-10 (Repeat of January session)  
Seminar on Newborn Radiology, Feb. 6-10 (Aspen, Colorado)  
Sixth Annual Symposium on Surgery of the Hand, Feb. 21-24  
High Risk Infant Care, Feb. 26-March 2 (Limited)  
Treatment of the Seriously Injured or Ill in the Emergency Department (American College of Surgeons), April 9-11  
Clinical Dermatology for the Family Physician, April 12-14 (Limited)  
Nineteenth Annual General Practice Review, June 11-16 (Estes Park, Colorado) (Repeat of the January and March session)  
Ophthalmology (59th Annual Course in Continuing Medical Education and Summer Convention of the Colorado Ophthalmological Society), June 2-5 (Colorado Springs)  
Ninth Annual Course in Internal Medicine, July 16-20 (Estes Park)  
Sixteenth Annual Course in Pediatrics, July 29-August 1 (Aspen)  
Dermatology, August 2-4 (Aspen)  
Tenth Annual Hospital Medical Staff Conference, Sept. 24-28 (Estes Park)  
High Risk Infant Care, Oct. 8-12 (Limited)  
Oral Cancer Seminar, Oct. 15  
Further information may be obtained by writing to the Continuing Medical Education office at the University, 4200 E. Ninth Ave., Denver 80220.

## South Carolina Offers PG Course in Surgery

The Medical University of South Carolina will conduct a postgraduate course in surgery on March 26 to 28 at the Mills Hyatt House, Charleston. Registration is limited to 100 participants. The fee is \$150, which includes breakfast and lunch on Monday. Write to John A. Moncrief, M.D., 80 Barre St., Charleston, S.C. 29401.

## Urologic Cancer Conference Announced for March 29-31

The National Conference on Urologic Cancer will be conducted by the American Cancer Society on March 29, 30 and 31, at the Shoreham Hotel, Washington, D.C. There is no registration fee. Advance registration is requested. Write Sidney L. Arje, M.D., 219 E. 42nd St., New York 10017.

## Wisconsin Offers Symposium

The Medical College of Wisconsin will conduct a one-day symposium on "Recent Advances in Gastrointestinal Endoscopy" on February 3 from 8 a.m. to 5 p.m. at the Wingspread Conference Center in Racine, Wis. The course is limited to 60 persons. For registration forms write to Dr. Joseph E. Geenen, 8700 W. Wisconsin Ave., Milwaukee 53233.



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# Deaths

## C. William Bugh, M.D.

Dr. C. William Bugh, 41, died at his home in Kendallville on Oct. 24.

A former member of the Marion County Medical Society, Dr. Bugh had arrived in Kendallville in September from Anchorage, Alaska, where he had practiced medicine for 13 years.

He was a graduate of the Indiana University School of Medicine and interned at the I.U. Medical Center. While in Alaska Dr. Bugh was a member of the Board of Medical Examiners.

## William H. Howard, M.D.

Dr. William H. Howard, Munster, a co-founder of the Indiana Blue Shield Plan, died Oct. 3 at the age of 76.

He had also served as president of the Indiana Plan and of the National Association of Blue Shield Plans. He was also a past president of the Indiana State Medical Association, the Lake County Medical Society and the St. Margaret Hospital medical staff.

A member of the American College of Surgeons, Dr. Howard was a graduate of the Indiana University School of Medicine.

## Maurice Rothberg, M.D.

Dr. Maurice Rothberg, Fort Wayne ophthalmologist, died October 9.

A native of New York City, Dr. Rothberg was graduated from the Indiana University School of Medicine in 1931 and was a member of the Allen County Medical Society, the American College of Surgeons and the Pan American Congress of Ophthalmology.

He had served as president of the medical staff of St. Joseph's Hospital, Fort Wayne.

## Samuel A. Farnsworth, M.D.

Dr. S. A. Farnsworth, 64, LaPorte, died at the E Street Division Hospital Oct. 30.

He was graduated from the University of Illinois College of Medicine, Chicago, in 1941, and licensed to practice in Indiana in 1942.

He was a member of the LaPorte County Medical Society.

## Owen B. Johnson, M.D.

Dr. Owen B. Johnson, 53, lifelong resident of Peru, died Oct. 16 at Veterans Hospital, Indianapolis, following an extended illness.

A graduate of the Tulane University School of Medicine, Dr. Johnson was a former Miami County coroner.

At the time of his death he was chief of obstetrics and gynecology at Dukes Memorial Hospital. He was a past president of the Miami County Medical Association.

## Frank W. Spellman, M.D.

Dr. Frank W. Spellman, 51, a general practitioner in Miller for 23 years, died October 11 in his home.

A native of Omaha, Neb., Dr. Spellman was a graduate of the School of Medicine at the University of Nebraska and interned at Mercy Hospital, Chicago, with a residency at Mercy Hospital in Gary following two years in the U. S. Army.

He was a member of the Lake County Medical Society and the American Medical Association.

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## *Indiana Medical Foundation, Inc.*

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.



# Association News

## BOARD OF TRUSTEES AND AMA DELEGATION

August 5, 1972

The meeting of the Board of Trustees and the AMA Delegation was convened upon call of the Chairman of the Board in the headquarters building at 6:00 p.m. Saturday, Aug 5, 1972. Roll call showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	H. C. Jackson	Present
5	Wilbert McIntosh	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
7	Dwight Schuster	Absent
8	Richard Ingram	Absent
9	William Sholty	Present
10	V. J. Santare	Present
11	Lowell J. Hillis	Present
12	W. R. Clark	Present
13	G. Beach Gattman	Present

### Alternate

Raymond Newnum	Absent
Betty Dukes	Absent
Thomas Neathamer	Present
W. F. Blaisdell	Absent
C. M. Schauwecker	Present
Glen Ward Lee	Present
Joseph F. Ferrara	Present
Joseph Kerlin	Absent
Jack Alexander	Present
Max N. Hoffman	Absent
Thomas Tyrrell	Present
James Harshman	Present
Walter D. Griest	Absent
Donald Chamberlain	Absent

### Trustees-elect

2	Paul W. Holtzman	Absent
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### Alternate Trustees-elect

5	William G. Bannon	Absent
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
10	Martin J. O'Neill	Absent

### Officers:

Peter R. Petrich	Present
James H. Gosman	Present

Lester H. Hoyt	Present
Hugh K. Thatcher, Jr.	Present
Frank B. Ramsey	Present

### Executive Committee:

Donald M. Kerr	Present
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### AMA Delegates and Alternates:

Eugene F. Senseny	Absent
Frank H. Green	Absent
Jack E. Shields	Present
Lowell H. Steen	Present
A. Alan Fischer	Present
P. J. V. Corcoran	Present

### Staff:

Robert J. Amick	Present
Howard Grindstaff	Present
John L. Walters	Absent
Kenneth W. Bush	Present
James A. Waggener	Present

### Guest:

Lee E. Mortenson	Present
(AMA Field Representative)	

The minutes of the meeting held June 10-11 were approved by motion of Dr. Petrich seconded by Dr. McIntosh. The Chairman of the Board then turned the meeting over to President Petrich.

**Special Reference Committee.** The president outlined his proposal for having a Special Reference Committee which would set forth the purpose of hearing complaints and suggestions not only about the AMA but also about the ISMA. After a full discussion of the composition of the committee, involvement of the AMA delegates, AMA trustees and other officers, upon motion by Dr. Wilhelmus duly seconded by Dr. Gattman, the president was authorized to proceed with his plan for this Special Reference Committee hearing.

**Resolutions.** The president then proposed several resolutions for submission to the House of Delegates of the AMA.

Resolution 1 — dealt with the attachment of a fiscal note to resolutions presented to the AMA House. This was discussed by several and editorial changes were made. Upon motion by Dr. Gosman, seconded by Dr. Hoyt to adopt the amendments, the secretary was instructed to have a rewritten resolution prepared for the next meeting of the Board.

Resolution 2 — dealt with the proposal that the Board of Trustees in all their reports calling for an expenditure of funds should also contain a fiscal note.

This resolution was discussed thoroughly with editorial changes being made. Upon motion by Dr. Gosman, seconded by Dr. Hoyt, the resolution, as amended, was approved with the secretary instructed to prepare an amended resolution for review by the Board at its October meeting.

Resolution 3 — dealt with the composition of tenure of office and matters referred to the AMA Reference Committee F. This resolution was discussed quite broadly and many recommendations and changes were suggested. Finally, upon motion by Dr. Hoyt, seconded by Dr. McIntosh, the secretary was instructed to rewrite this resolution and submit it for the October meeting of the Board for their consideration.

Resolution 4 — presented by Dr. Harshman, concerning nominating speeches and seconds for the elections of officers of the AMA House of Delegates, was widely commented upon, including a comment that such a resolution should also be introduced in the ISMA House of Delegates. Upon motion by Dr. Gosman, seconded by Dr. Dukes, it was moved that the resolution be introduced; however, a vote was not taken. Further discussion took place and, upon motion by Dr. Goodman, seconded by Dr. Gosman, this resolution was tabled until the next meeting of the Board.

**Election of Floor Leader.** The next matter under discussion concerned the AMA delegation, specifically dealing with the election of the floor leader. Dr. Goodman moved that the delegates should elect a floor leader; this motion was later withdrawn. A motion was then made by Dr. Sholty, seconded by Dr. Ferrara, that a secret ballot be used for the purpose of electing a floor leader. This matter was discussed very broadly with the recommendation also being made that the election take place annually, prior to the annual session of the AMA. It was moved by Dr. Goodman, seconded by Dr. Clark, that a committee be appointed to report back at the next meeting of the Board. By consent, the Chair appointed Drs. Steen, Harshman, and Goodman to constitute this committee.

**AMPAC Board Vacancy.** The next item discussed was the recommendation of the ISMA for a member to fill a vacancy on the AMPAC Board. Dr. Hoyt nominated Dr. Senseny of Fort Wayne and Dr. Butler placed the name of Dr. McIntosh in nomination. The two candidates were discussed and, upon motion of Dr. Goodman, seconded by Dr. Ferrara, this matter was tabled until



the executive session of the Board the following day.

**Adjournment.** There being no further business, the meeting was recessed until 8:00 a.m. Sunday, August 6, 1972.

BOARD OF TRUSTEES

Aug. 6, 1972

Dr. Joe Dukes, Chairman, convened the meeting of the Board of Trustees in the headquarters building of Indiana State Medical Association at 8:30 a.m. Sunday, August 6, 1972.

ROLL CALL showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Absent
5	Wilbert McIntosh	Present
6	Paul Inlow	Absent
7	John O. Butler	Present
7	Dwight W. Schuster	Present
8	Richard Ingram	Absent
9	Wm. Sholty	Present
10	Vincent Santare	Present
11	Lowell J. Hillis	Present
12	Wm. Clark	Present
13	G. Beach Gattman	Present

Alternate Trustee

Raymond Newnum	Absent
Betty Dukes	Absent
Thomas Neathamer	Present
William Blaisdell	Absent
Cleon Schauwecker	Present
Glen Ward Lee	Present
Joseph Ferrara	Present
Joseph C. Kerlin	Absent
Jack L. Alexander	Present
Max N. Hoffman	Present
Thomas C. Tyrrell	Present
James A. Harshman	Present
Walter D. Griest	Absent
Donald Chamberlain	Absent

Trustees-elect:

2	Paul W. Holtzman	Absent
5	C. M. Schauwecker	Present
7	Joseph Ferrara	Present

Alternate Trustees-elect:

5	William Bannon	Absent
7	Donald McCallum	Absent
7	John G. Pantzer	Present
10	Martin O'Neill	Absent

Officers:

Peter R. Petrich	Present
James H. Gosman	Present
Lester H. Hoyt	Present
Hugh K. Thatcher	Present
Frank B. Ramsey	Present

Executive Committee:

Donald M. Kerr	Present
Wilbert McIntosh	Present

AMA Delegates and Alternates:

James A. Harshman	Present
Eugene Senseny	Absent
Frank H. Green	Absent
Jack Shields	Present
Lowell H. Steen	Present
A. Alan Fischer	Absent
Eugene S. Rifner	Present
K. O. Neumann	Present
P. J. V. Corcoran	Present
Thomas C. Tyrrell	Present

Staff:

Robert J. Amick	Present
Howard Grindstaff	Present
John L. Walters	Absent
Kenneth W. Bush	Present
Jas. A. Waggener	Present

Guest:

Lee Mortenson	Present
(AMA Field Representative)	

MINUTES OF THE MEETING HELD June 10 and 11 were approved on motion of Dr. Petrich and seconded by Dr. McIntosh, with the following correction to be made on page 10 of the minutes—strike the word “president” and insert in lieu thereof the word “association” making the last sentence of Dr. Goodman’s motion read: “I move that we accept it and that the association write a letter of thanks to the A. H. Robins Company”.

Remarks of the President

DR. PETRICH: The program for the state meeting—I had intended to have Paul Rogers, Florida Representative, as one of the three speakers on Tuesday afternoon. However, since Mr. Rogers is in a race for re-election and not going outside of Florida, he will not be present. We do, however, have Dr. Roth, President-Elect of the AMA, and Congressman Peter N. Kyros, (D) of Maine, as two speakers, and there will be a third. I would suggest that prior publicity be sent to non-medical individuals who

might be interested in the program—perhaps a ticket arrangement for this particular section of the meeting. You know in the past we have invited the community to meetings such as this.

He pointed out that the commissions and committees have worked hard this year and have spent wisely the money appropriated and urged the trustees to get their reports in early.

Remarks of the President-elect

Dr. Gosman pointed out that he is currently in the process of making the committee and commission appointments and would like to have the appointment suggestions from the trustees as to vacancies that are to be filled in their particular districts. He also suggested that they contact these individuals whom they might recommend in advance to see if they would be willing to serve before submitting the name to him. Inasmuch as the commissions and committees are the right arm of the association, he urged the selection of young blood to be interspersed in the commissions and committees, in order to get a younger person’s viewpoint, as there are many problems which could be given them for study and recommendation to the Board.

Report of the Treasurer

The treasurer reviewed the financial situation of the association and also the projections for the end of the year thinking at this meeting the association winds up the year slightly in the black. On motion of Dr. Hoyt, seconded by Dr. Gosman, the treasurer’s report was accepted.

Report of the Board Finance Committee

Dr. Wilhelmus, chairman of the Finance Committee, gave a report as to whether it would be necessary for a dues increase. In view of the treasurer’s report, just heard, it was the opinion of the Finance Committee at this time that a dues increase will not be needed this year unless further recommendations should come from the Executive Committee or the Board of Trustees. On motion of Dr. Wilhelmus and seconded by Dr. Gosman, the Finance Committee’s recommendation will be sent to the House of Delegates.

Editor of the Journal

Dr. Ramsey made a financial report of *The Journal* and said they were close in line with the budget. He reported the



number of requests that had been received for the print of the July issue cover. The August issue is the first one printed by the new printer and it is now hoped that *The Journal* will be back on the regular schedule, pointing out that the August issue was in the mail on August 4th.

### Introduction of New Members

Dr. Gosman, at this time, introduced Dr. John Pantzer of Indianapolis, the new alternate-trustee-elect from the 7th District.

### Matters Referred to the Executive Committee

DR. KERR discussed a letter from Dr. Inlow relative to a request from Rush County for the state association to certify the need for public health physician in their county. In attempting to establish the policy of having such physicians sent to areas in need, each request is to be brought before the Board for investigation and approval. The list of physicians serving in the county was read together with the ratios. Rush County is reported to have a population of 20,352.

Dr. Lee moved and Dr. Santare seconded that the Board approve forwarding such certification to HEW for a public health physician for Rush County. The motion was further discussed and, motion was made by Dr. McIntosh, seconded by several, that this matter be tabled until the trustee for this district is back from vacation and more information can be obtained. The motion carried with Dr. Santare and Dr. Lee voting against the motion.

Entertainment, Board of Trustees Annual Formal Dinner—

DR. KERR: Relative to the Board of Trustees Dinner at the state convention, Dr. Petrich suggested that a professional group of musicians be hired to play for the reception, dinner and dancing and the approximate cost is \$300 or \$20 to \$25 per person. The cost of this is borne by the trustees. Upon motion of Dr. Petrich, seconded by Dr. Gosman, he was authorized to proceed with the plan and spend \$300 for musical entertainment. The motion was carried.

We have discussed Dr. Petrich's idea to establish some alternate or supplementary way of financing the convention, and would like to have the finance committee proceed to do so or have a dues increase, which will be necessary in the future. Upon motion of Dr. Petrich, seconded by Dr. McIntosh, it was decided to

appoint an expanded finance committee which would be empowered to obtain methods of financing the annual convention for the meeting in 1973.

DR. DUKES: I will appoint the committee to assist Dr. Wilhelmus as chairman: Dr. Hillis, Dr. Goodman, Dr. Joe Ferrara, Dr. James Harshman, Dr. Martin O'Neill and Dr. Hoyt.

Dr. Wilhelmus was of the opinion that the convention should be financed from the General Fund and the secretary stated that this year's meeting will more than wipe out the now-existing profit.

### Reports of Trustees and Requests for Remission of Dues:

1st District: Dr. Wilhelmus — Our 1973 meeting will be held in Evansville on May 10th.

2nd District: Dr. Dukes — Our 1973 meeting will be held in Bloomington but the date has not been set.

3rd District: Dr. Goodman — Our 1973 meeting will be held at the Marriott Inn at Clarksville in September but the date has not been set.

4th District: No report

5th District: Dr. McIntosh—Our 1973 meeting will be held in Greencastle May 2nd.

6th District: Dr. Lee — Our 1973 meeting will be held in Rushville and the date has not been set.

7th District: Dr. Schuster — The 1973 meeting will be held at the Indianapolis Speedway Motel on June 1.

8th District: Dr. Alexander — I understand our district meeting will be held in '73 in Muncie on June 2nd.

9th District: Dr. Sholty — Our 1973 meeting will be held June 14th in Lafayette.

10th District: Dr. Santare — Our 1973 meeting will be held at the Lake of the Four Seasons at Hebron on May 30th.

11th District: Dr. Hillis — The 1972 meeting is scheduled for September 20th at Stellite Park, ten miles west of Kokomo, and you are all invited to come.

12th District: Dr. Clark — Our 1972 meeting will be held September 14th at Schuler's in Fort Wayne. We promise you a gala evening if you will come join us.

13th District: Dr. Gattman: Our 1972 meeting is scheduled for September 13th at Michigan City. We also extend to you an invitation to visit with us at this time.

Remission of Dues: Upon motion of Dr. Wilhelmus and seconded by Dr. Mc-

Intosh, the dues of Dr. Charles Schneider of Evansville were remitted.

On motion of Dr. Dukes and seconded by Dr. McIntosh, the dues of Dr. Robert E. Lyons of Bloomington and Marcel S. Brown of Spencer were remitted.

On motion of Dr. McIntosh and seconded by Dr. Wilhelmus, the dues of Dr. Robert Webster and Dr. John Shattuck of Brazil were remitted.

Senior membership for Dr. Paul S. Rhoads of Richmond — Mr. Waggener pointed out that, under the present Constitution and Bylaws, Dr. Rhoads was not eligible for senior membership. He further pointed out that in 1952 the Commission on Constitution and Bylaws presented an amendment to the constitution, Article IV, Section 4, to permit physicians past 70 years of age, who had been a member not only of ISMA but other state associations for a period of twenty years, to be eligible for senior membership. For some reason or other, this was never presented to the House for final approval.

Following this explanation, upon motion of Dr. Lee and seconded by Dr. Gosman, this matter was laid on the table. Dr. Sholty suggested he might be eligible for honorary membership and Dr. Gosman moved, seconded by Dr. Wilhelmus, to take this to the House to present Dr. Rhoads with honorary membership. The motion was carried.

### Reports from Board Committees:

Proposal for reorganization of Local Health Departments. The committee consisting of Dr. Gosman, Dr. Goodman and Dr. Sholty discussed this proposal with local health officers. Dr. Gosman stated that the committee did not want to give judgment at this time as they are not absolutely sure that this proposal should be adopted and further stated that the committee plans to see if they could have something objective for the Legislative Commission before the convening of the Legislature. Upon motion of Dr. Gosman, seconded by Dr. Petrich, this matter was deferred until such time as more information can be obtained.

Resolution to Rescind Resolution 26. The Committee consisting of Dr. Santare, Dr. Harshman and Dr. Ingram reviewed the background of Resolutions 26 and 12. The committee recommends that the Board of Trustees suggest to the Board of Directors of Blue Shield that the problem is not with Resolution 26 but is with the administration of the Plans (such as updating profiles, determining fees, ability of Blue Shield to sell usual



and customary without proper review). Following discussion, Dr. Goodman moved that the recommendation be accepted. Dr. Goodman's motion lost for lack of a second. Dr. Hoyt then moved, seconded by Dr. Petrich, that the matter of recommending repeal of Resolution 26 to the House of Delegates be dropped. The motion was carried.

A discussion was then held concerning the methods which doctors might use to collect their usual and customary fees regardless of what third parties might pay.

On motion of Dr. Petrich, seconded by Dr. Gosman, it was voted that we inform Blue Shield board members to take strong action on their administration in line with the Ad Hoc Committee report.

Dr. Santare suggested that a Peer Review Committee be established and Dr. Neumann stated that several pertinent suggestions had been offered in the annual report of the Commission on Medical Economics and Insurance. The matter was further discussed by Dr. Neathamer, who believes that Resolution 26 should be sent to the House of Delegates. Upon motion of Dr. McIntosh, seconded by Dr. Goodman, previously recommended by the Ad Hoc Committee, that a Board Committee meet with physician directors of Blue Shield at some immediate future date before the October meeting. Dr. Hillis moved to amend the original motion by saying "before October 1." Seconded by Dr. Petrich and accepted by consent. In further discussion it was agreed that the committee would attempt to set Sunday, August 27 at 10:00 a.m. or, as an alternate, the next available Sunday after that, for such a meeting.

On motion of Dr. Goodman, seconded by Dr. McIntosh, it was moved that the physician members of Blue Cross also be invited to attend this meeting.

\$10,000 Gift to Indiana Medical Historical Museum. The committee consisting of Drs. Gosman, Sholty and Ingram reported through Dr. Gosman, who stated that the \$10,000 would come from the Indiana Medical Education Foundation fund and will be given to the Indiana Medical Historical Museum. If and when it is possible to generate \$10,000 from another source, the money will be given back to the educational fund. A committee from ISMA and Dr. Bonsett will be formed to help in this particular project. The University will use this Museum as a place for educational lectures, etc. The Museum cannot now be

torn down because it is classified as a historical landmark.

#### **Reports of Committees and Commissions:**

Resolution from the Commission on Special Activities Concerning Group Practice for Board approval for submission to the House of Delegates was reviewed and, upon motion of Dr. Petrich, seconded by Dr. Gosman, the resolution was approved for presentation to the House.

#### **Economic and Organization Matters:**

Membership Report. The membership report was reviewed and discussed quite at length, with it being pointed out that we were in danger of losing an AMA delegate if we did not pick up more AMA members. Following a lengthy discussion by several, it was suggested that the list of non-members of AMA and ISMA be broken down and distributed to the trustees for their information and action.

#### **Disposition of Matters Referred by the 1971 House of Delegates:**

(1) That the president, president-elect, and appropriate trustee visit one-third of all county societies each year. It was pointed out that this was being accomplished.

(2) Preparation and distribution of an ISMA Policy Manual in loose-leaf form. Mr. Waggener reported that it would be costly to compile and publish information in this manner. Upon motion of Dr. Hillis seconded by Dr. Clark, the motion was made to reject this recommendation but to point out that these things are currently being printed from time to time in *The Journal*. The motion was carried.

(3) Establishment by County Societies of Emergency Medical Care Plans. Upon motion of Dr. Hoyt to heartily endorse this and give support to such Emergency Medical Care Plans, seconded by Dr. Goodman, put to vote and carried. Doctor Schauwecker will submit the plans to Dr. Ramsey, editor, for inclusion in *The Journal*.

(4) Adequate Financing of Public Information Program. Dr. Gosman mentioned that there would probably be a report from the Public Information Commission that would cover this and they would submit a fiscal note.

(5) Computerization of Services to Membership. Following discussion of this, upon motion of Dr. Gosman, sec-

ond by Dr. Santare, it was voted that a separate committee be established to study this particular problem of computerized programming which extend into the services of billing, completing of insurance forms, etc., for the membership of ISMA.

(6) Recommendation to Charge Appropriate Commission to use outside help, if necessary, to prepare training programs for members and their non M.D. staff in human relations, use of telephone, etc.

Following a discussion, the motion was made by Dr. Petrich, seconded by Dr. Wilhelmus, that the Association attempt to improve our communications with these particular existing groups in lieu of this recommendation.

(7) Re-evaluation of Student Loan Program. The matter was discussed by Dr. Petrich, Dr. Dukes, Dr. Hoyt and Dr. Thatcher. Following discussion, upon motion of Dr. Gosman, seconded by Dr. Clark, it was moved that the Student Loan Program be left as is.

(8) Relative Value Schedule—Survey of Physicians to Develop Usual and Customary Fees. Following discussion of this matter, it was moved by Dr. Schuster and seconded by Dr. McIntosh that the executive secretary develop a plan to survey the physicians as to their normal fees for more common procedures.

Following passage of the motion, Dr. Steen recommended that we might attempt to contact the specialty groups as most of them do have fee schedules.

(9) Establishment of Foundations by County Societies or State to Act as Fiscal Agent for Medicaid. It was pointed out that the Future Planning Committee and the Commission on Medical Economics and Insurance met jointly to discuss the establishment of foundations and they have made a report to the House of Delegates.

Upon motion of Dr. Petrich, seconded by McIntosh, it was voted to continue to study Foundations through the committee and commission.

(10) Resolution 71-24. It was pointed out that this matter was taken care of at the March 5th meeting of the Board.

#### **New Business:**

Nomination of two members of the Trust Committee of the Indiana Medical Education Foundation.

On motion of Dr. McIntosh, seconded by many, it was voted to re-elect Dr. Don Wood to this committee.

Upon motion of Dr. Hillis, seconded by many, Dr. Eugene Rifner was elected to membership of this committee.



Two members of the Editorial Board. Membership on the Editorial Board was discussed and, upon recommendation of Dr. Petrich, a committee was appointed by the Chair to secure nominations for the Editorial Board. The committee is to consist of Dr. Lee, Dr. Ramsey and Dr. Ferrara.

#### **Unfinished Business:**

A Fact Sheet on Medicaid. Dr. Petrich reviewed that at the last meeting he had proposed that the ISMA staff prepare a Medicaid Fact Sheet similar to that prepared on Medicare. The format and copy were presented to the Board and, on motion of Dr. Petrich, seconded by several, it was voted to accept the proposed copy and format and that they be printed in leaflet form for distribution. The motion was carried.

Resolution from the Board to the House of Delegates Requiring Fiscal Note to be made a part of any report or resolution requiring expenditure of funds. Upon motion of Dr. Gosman, seconded by Dr. McIntosh, the resolution was approved for presentation.

Resolution to the House of Delegates Giving SAMA Representative the Right to Vote. In discussing this, Dr. Gosman moved that we establish a Section for Interns and Residents and also give them a vote in the House of Delegates. The motion was seconded by Dr. Hoyt. Discussion ensued concerning the motion and Dr. Hoyt moved to amend the motion that the Board recommend they be given one delegate and one alternate. Dr. Gosman seconded this amendment which was then put to vote and carried. The original motion, as amended, was then put to vote and carried. (Secretary's note: There is no reference on the tape concerning an actual motion to approve the resolution to give SAMA the right to vote in the House of Delegates).

Resolution establishing a \$2,000 limit for Medical Defense Cases. Dr. McIntosh moved to establish a \$2,000 limit for Medical Defense Cases subject to review by the Executive Committee. The motion was seconded by Dr. Santare and carried. The secretary then made the point that this motion deleted the resolution to be taken to the House. Following this, upon motion by Dr. Schuster and seconded by Dr. McIntosh, it was moved that this resolution not be submitted to the House of Delegates.

Further discussion was held on the manner of handling this, such as informing the member of any limitation, and Dr. Hoyt pointed out that this was already provided for in the Bylaws of the

Medical Defense Committee.

Dr. Petrich then moved to have the executive secretary and the Executive Committee prepare a brief white paper report regarding the Medical Defense Fund and possible future implications to be sent to the House.

The motion was seconded by Dr. Hoyt, put to vote and carried.

Resolution 71-3. Dr. Petrich moved that Resolution 71-3, which was discussed on June 11 and was amended, be sent back to the House for reconsideration. The motion was seconded by many and carried.

Dr. Santare then reviewed the HEW's treatment of children's health problems, pointing out that the State Welfare Department is being asked to implement a law which would provide physical examination and treatment for all children under 21 years of age. Mr. Waggener pointed out that State Department of Welfare had estimated the cost to the state of Indiana would be some 50 million dollars per year and the AMA has not made a commitment on this particular law. Dr. Gosman pointed out that it might be of some value to point this out to the public and take it to the candidates for the state legislature. Dr. Petrich commented that he thought it was essential that we make our position known to everyone, especially to the men in Congress.

There being no further business, the committee adjourned to meet again at 12:00 noon Saturday, October 14, at the Indianapolis-Exposition Center.

## **EXECUTIVE COMMITTEE**

October 14, 1972

The Executive Committee convened at 9:00 a.m. on Saturday, October 14, 1972, in Room 225 of the Indiana Convention Center with Donald M. Kerr, M.D., chairman, presiding.

ROLL CALL showed the following present: Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Peter R. Petrich, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Frank B. Ramsey, M.D., James A. Waggener, and guest, Cleon Schauwecker, M.D.

MINUTES OF THE MEETING held September 27, 1972, were approved on motion of Dr. Petrich and a second by Dr. McIntosh.

#### **Headquarters Office**

**CHARGES FOR AUXILIARY WORK** — The Secretary requested interpreta-

tion of the policy concerning office secretarial work and duplicating work done for the Auxiliary and, on motion of Dr. McIntosh seconded by Dr. Petrich, the secretary was instructed that this work be done at no charge to the Auxiliary.

**BOILER WORK** — The secretary reported that the work on the boiler, as approved at the last meeting of the Executive Committee, had been completed.

#### **Treasurer's Report**

The Treasurer's report was approved on motion of Dr. Hoyt and Dr. McIntosh. On motion of Dr. Petrich seconded by Dr. McIntosh, the Association is to write a letter to Doctor Hoyt commending him for his faithfulness and dedicated service as treasurer of the Indiana State Medical Association for the last five years.

On motion of Dr. Gosman seconded by Dr. McIntosh, it was voted that a resolution of commendation for Treasurer Hoyt's service be presented to the House of Delegates.

#### **Convention Matters**

**SHUTTLE BUS** — The secretary announced the schedule for the shuttle bus service sponsored by the I. U. Alumni Foundation.

**BRAUN SHOW, 50-50 Club** — The secretary reported that because of a strike, the 50-50 Club show scheduled for Monday, October 16, had been cancelled.

#### **Organization Matters**

**CONNERSVILLE MATTER** — The secretary read a letter from the State Medical Board of Registration and Examination to the Fayette-Franklin County Medical Society concerning the Connersville matter which has been under discussion for the past several months.

**MEMBERSHIP INDIANA TRAFFIC SAFETY COUNCIL** — Membership in the Indiana Traffic Safety Council was approved on motion of Dr. McIntosh seconded by Dr. Gosman.

**REQUEST OF WOMAN'S AUXILIARY** — The request of the Woman's Auxiliary for the annual \$1,000 subsidy was read, and payment of this amount was approved on motion of Dr. McIntosh, seconded by Dr. Dukes.

**APPOINTMENT TO AMA COMMIT-**



**TEE ON SPORTS AND MEDICINE —** Membership on the AMA Committee on Sports and Medicine in which a recommendation had been made for Dr. Kerr to be a member, and which was referred to Dr. Gattman, Trustee for the district, was discussed and Dr. Gattman's reply was read. Dr. Kerr was approved for membership on this Committee on motion of Dr. McIntosh and Dr. Gosman.

**NEVADA PHYSICIANS UNION —** The secretary reported he had had a letter together with the articles covering the organization of the Nevada Physicians Union and this was taken as a matter of information.

**RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND —** A report of the Kentucky Medical Scholarship Fund was reviewed and, on motion of Dr. Gosman and taken by consent, this matter is to be referred to the Commission on Special Activities and the Commission on Legislation.

**REPORT ON H.R. 1 —** The secretary reported on a telephone conversation he had had with the Washington office of the AMA concerning the provisions of H.R. 1 which were adopted by the Conference Committee of the House and Senate.

**REGULATIONS ON DISCLOSURE —** Proposed Federal regulations concerning information to be disclosed under the Medicare Program was reviewed and taken as a matter of information.

**BLUE SHIELD LETTER TO S.S.A.—** A letter from Indiana Blue Shield to S.S.A. objecting to some of the provisions of the proposed legislation was reviewed and taken as a matter of information.

**BLUE SHIELD CHIROPRACTIC PROBLEM —** The opinion of the Commissioner of Insurance concerning the exclusion in the Blue Shield contract of chiropractic service was reviewed, as was a letter from ISMA legal counsel, and these were taken as a matter of information.

**BALLOT TO BE CAST BY AMA DELEGATES —** A ballot to be cast by the delegates to the AMA Clinical Session in Cincinnati concerning the tenure of AMA trustees was reviewed and, on motion of Dr. McIntosh seconded by Dr. Dukes, this was referred to the Board of Trustees.

**BLUE CROSS-BLUE SHIELD MINUTES —** Several matters in the Blue Cross-Blue Shield minutes were called to the attention of the Committee for their information.

**HEW MEMO INCREASE IN HOSPITAL DEDUCTIBLE —** A memo from HEW concerning an increase in the hospital deductible under the Medicare Program was reviewed for the information of the committee.

**ST. LOUIS MEDICAL SOCIETY LETTER —** A letter from the St. Louis Medical Society addressed to the president concerning a plan adopted by that society in insurance matters was reviewed and, on motion of Dr. Petrich, seconded by Dr. Gosman, this matter is to be referred to the Commission on Medical Economics and Insurance.

**LETTER FROM AN INDIANA PHYSICIAN —** A letter written by an Indiana physician concerning his apparent inability to become a member of his county medical society was discussed and, on motion of Dr. Dukes seconded by Dr. McIntosh, this is to be referred to the trustee in the district involved.

**MATTERS TO COME BEFORE THE HOUSE OF DELEGATES —** The matters to come before the House of Delegates were called to the attention of the committee for their information.

#### **Legal Matters**

An application for medical defense by a member was approved on motion of Dr. Petrich seconded by Dr. McIntosh, with the secretary being instructed to get a fee schedule for the attorney involved.

A letter from another member concerning a threatened suit against him was reviewed and the secretary is instructed to send him an application for medical defense.

#### **New Business**

The President's speech was then distributed to the committee for their review and, on motion of Dr. Hoyt seconded by Dr. McIntosh, his speech was approved.

A request from the Associated Distributors, Inc., seeking permission to use the mailing list to advise doctors of the new RCA Whirlpool Trash Master Compactor was turned down by consent.

On motion of Dr. Gosman seconded by Dr. McIntosh, it was voted to prepare a plaque for Dr. Offutt and the wording of such a plaque was approved.

#### **Future Meetings**

A notice of a Regional meeting of the Health Insurance Council to be held in St. Louis November 2 - 3 was read and no representative will be sent.

An invitation for representatives to be sent to the National Joint Practice Commission meeting to be held in Itasca, Illinois, on November 9 - 10 was discussed. On motion by Dr. Gosman seconded by several, Dr. Frank Bryan and Dr. Warren Coggeshall are to be requested to represent the Association.

A notice of the Occupational Safety Health Conference to be held in Indianapolis November 14 - 15 is to be referred to the Commission on Public Health.

There being no further business, the committee adjourned to meet again immediately following the organizational meet of the Board of Trustees on Wednesday October 18, 1972.

## **EXECUTIVE COMMITTEE**

October 18, 1972

The organization meeting of the Executive Committee was convened by President Gosman in the VIP Suite of the Indiana Convention Center immediately upon the conclusion of the organization meeting of the Board of Trustees.

ROLL CALL showed the following present: James H. Gosman, M.D., Joe Dukes, M.D., Gilbert Wilhelmus, M.D., Hugh K. Thatcher, M.D., Donald M. Kerr, M.D., Vincent J. Santare, M.D., Arvine Popplewell, M.D., and James A. Waggener.

By secret ballot Dr. Donald M. Kerr was reelected Chairman of the Executive Committee.

The date for the next meeting of the Executive Committee was set for November 18 at 8:00 p.m. in the Headquarters Building, with sandwiches to be available.

There being no further business, the meeting was adjourned. ◀



# The Convention Story



JUST three weeks before he was elected Governor of Indiana, Dr. Otis Bowen addressed the House of Delegates.



THE registration desk was on the main floor just outside the doors of the Exhibit Hall.





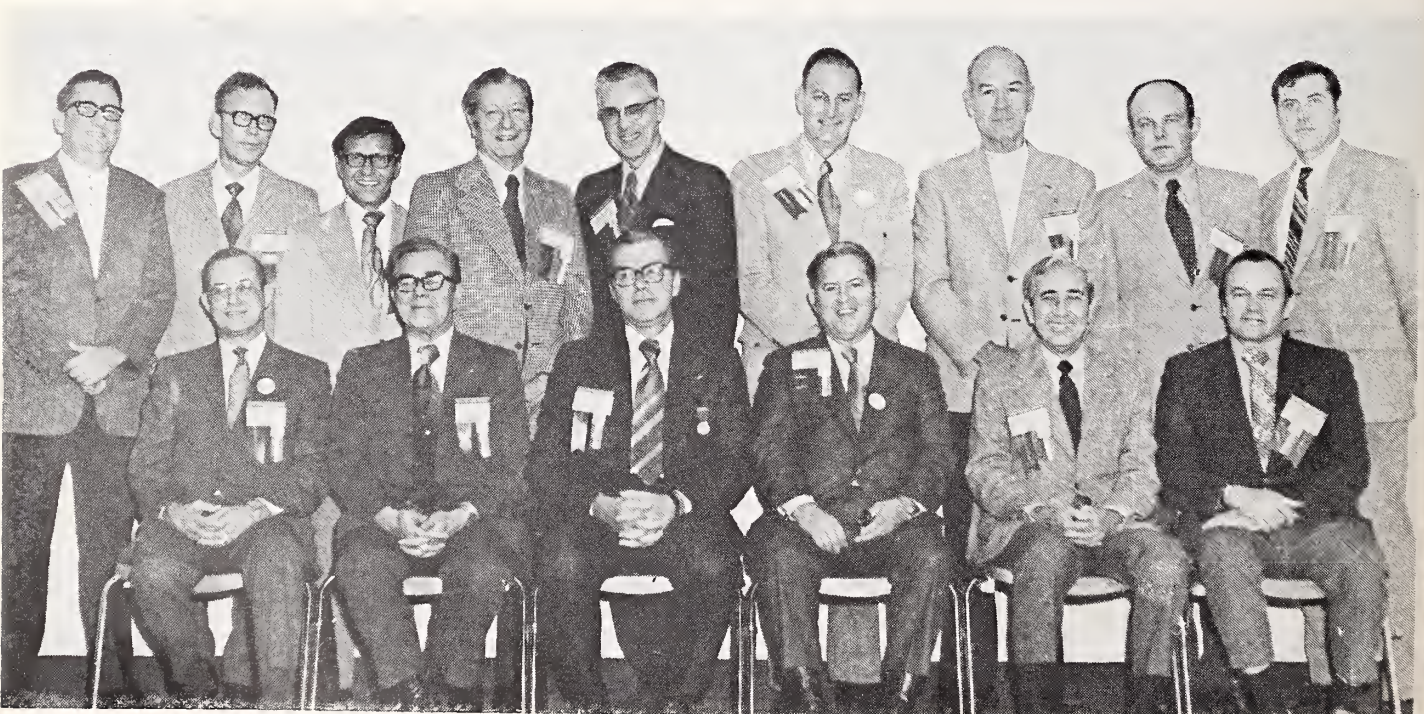


THE annual Art and Hobby Show had a wide variety of entries and was a popular spot for convention visitors.



IT was a happy group which boarded the bus for the trip to the Indiana University School of Medicine and Marion County General Hospital.

THE Board of Trustees and officers were nearly all present for an informal picture.







DR. WEI-PING LOH was a guest at the Women Physicians' dinner on Monday night and afterwards gave a talk on acupuncture.



Monday's bus tour included stops at the I. U. Medical Center and the Marion County General Hospital, where this lab was visited.

OUR photographer caught part of the crowd in attendance at the acupuncture program sponsored by the Women Physicians of Indiana.







*The House of Delegates in session.*







A few of the section meetings and group luncheons were: (clockwise) Indiana Philippine Medical Association, Section on Internal Medicine and American College of Physicians and Indiana Society of Internal Medicine, ISMA Past Presidents, OB-GYN Section and Indiana OB-GYN Society, and the Editorial Board of THE JOURNAL.





DR. PETRICH presented the ISMA Award of Merit to writer Leilo Holmes of THE INDIANAPOLIS STAR for the second year in a row.



HE presented the A. H. Robins Company award for community service to Dr. Robert W. Kuhn, Wilkinson.



ANOTHER award of merit was presented by Dr. Petrich to WISH-TV staffer Bill Crofton. (far left)

DR. WEI-PING LOH made the awards to the Scientific Exhibit award winners. Above right is Allan A. Kotzberg, Ph.D., who received the Aesculapius Award, courtesy of Eli Lilly and Company. For right is Dr. R. Denison Stewart who accepted the second place award for a group of doctors of the Cleveland Clinic. Leonard Gottesman, M.D., Cincinnati, was awarded third place for his exhibit.



"PHYSICIAN OF THE YEAR" was the recognition awarded Dr. John P. Scherschel, (right), Bedford, by Mr. John R. Dunigon for the Indiana Mental Health Association.





A few of the members of the 50-Year Club who attended the President's Dinner Tuesday night are shown.



THERE was dancing after dinner.



AND a reception preceding dinner.



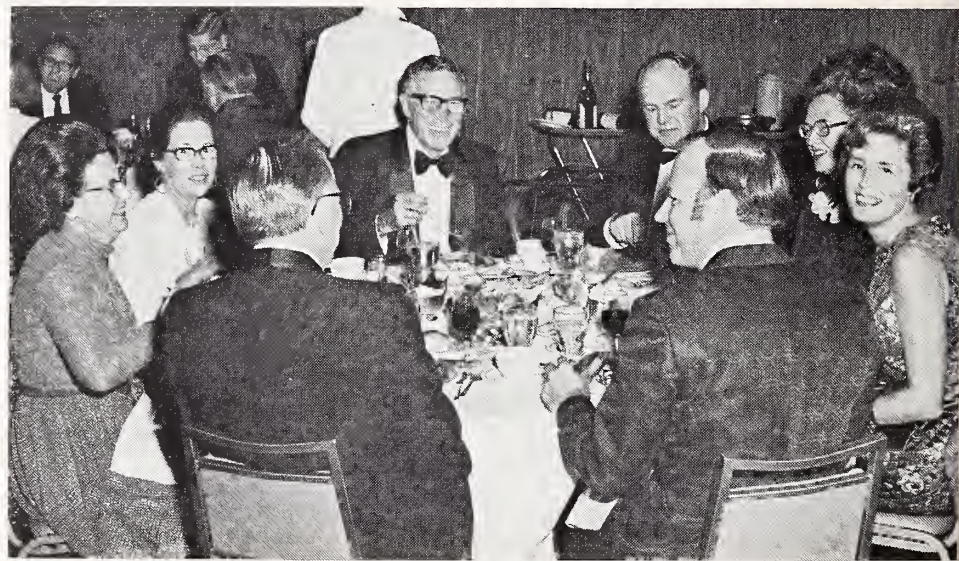




DR. PETER R. PETRICH attained past president status when he presented the president's medal to Dr. Gosman.



A part of the group at the President's reception Tuesday night.



TWO scenes at the annual Trustees' Dinner at the Hilton Hotel on Saturday night.





# Convention Election Results

## Dr. Joe Dukes Named President-Elect

Dr. Joe Dukes, Sullivan, was elected president-elect of the Indiana State Medical Association at the closing session of the House of delegates in October. He succeeds Dr. James H. Gosman, Indianapolis, who was installed as president on October 17.

(An account of the career and service to organized medicine of Doctor Gosman appeared in the November *Journal*.)

Dr. Hugh K. Thatcher, Jr., Indianapolis, was elected treasurer, and Dr. Arvine K. Popplewell, Indianapolis, was elected assistant treasurer.

Dr. Gilbert M. Wilhelmus, Evansville, was elected chairman of the Board of Trustees, while Dr. Donald M. Kerr of Bedford was re-elected chairman of the Executive Committee.

New trustees chosen for three-year terms by their districts are: Dr. Paul W. Holtzman, Bloomington, District 2; Dr. Cleon M. Schauwecker, Greencastle, District 5; Dr. Joseph F. Ferrara, Franklin, District 7; and Dr. James A. Harshman, Kokomo, District 11.

Dr. Richard Ingram, Montpelier, was re-elected to a three-year term as trustee representing District 8.

Newly elected alternate trustees are: Dr. William G. Bannon, Terre Haute, District 5; Drs. Donald McCallum and John G. Pantzer, Jr., Indianapolis, District 7; and Dr. Martin O'Neill, Valparaiso, District

10. Dr. Lloyd L. Hill, Peru, District 11, was elected to fill the unexpired term of Doctor Harshman.

### New Section Officers

Results of the various Section elections are as follows:

*Section on Surgery:* Chairman, Malcolm L. Wrege, Indianapolis; vice chairman, J. Robert Edwards, Auburn; secretary, Lowell Hillis, Logansport.

*Section on Internal Medicine:* Chairman, Robert L. Rudesill, Indianapolis; vice chairman—John L. Ferry, Hammond; secretary, Charles W. Magnuson, South Bend.

*Section on Family Physicians:* Chairman, James T. Anderson, Greenfield; vice chairman, James R. Daggy, Richmond; secretary, David M. Hadley, Plainfield.

*Section on Obstetrics and Gynecology:* Chairman, Jerome F. Doss, Kokomo; vice chairman, David E. Copher, Indianapolis; secretary, Charles R. Thomas, Indianapolis.

*Section on Ophthalmology and Otolaryngology:* Chairman, Kenneth Isenogle, Fort Wayne; vice chairman, Wallace Dyer, Evansville; secretary, David Kenney, Indianapolis.

*Section on Anesthesiology:* Chairman, Willis W. Stogsdill, Indianapolis; secretary, David P. Lehman, Kokomo.

*Section on Public Health and Preventive Medicine:* Chairman, Fred

Poehler, LaFontaine; vice chairman, Robert M. Seibel, Nashville; secretary, David J. Edwards, Indianapolis.

*Section on Radiology:* Chairman, Dale B. Parshall, Elkhart; vice chairman, James G. Lorman, Fort Wayne; secretary, L. Ray Stewart, Evansville.

*Section on Nervous and Mental Diseases:* Chairman, Wesley A. Kissel, Indianapolis; vice chairman, Wallace R. Van den Bosch, Lafayette; secretary, Richard N. French, Jr., Indianapolis.

*Section on Pathology and Forensic Medicine:* Chairman, Clyde Culbertson, Indianapolis; president-elect, Wei-Ping Loh, Gary; secretary, Victor Muller, Indianapolis.

*Section on Pediatrics:* Chairman, George F. Parker, Indianapolis; vice chairman, John R. Poncher, Valparaiso; secretary, Robert M. Sweeney, South Bend.

*Section on Directors of Medical Education:* President, Lindley H. Wagner, Lafayette; vice president, John L. Cullison, Muncie; secretary, W. Thomas Spain, Evansville.

*Section on Cutaneous Medicine:* Chairman, Jere D. Guin, Kokomo; vice chairman, Howard R. Gray, Indianapolis; secretary, Victor G. Hackney, Indianapolis.

*Section on College Health Physicians:* Chairman, John M. Miller, Bloomington; secretary, Wayne G. Pippenger, Muncie. ◀



# THE WINNERS—123rd Annual Convention

## Indianapolis, Oct. 14-18, 1972

### ART AND HOBBY SHOW

Best of Show (Women's Division) "Balloon Boy" (batik), Mrs. Robert Brubeck, Martinsville

Best of Show (Men's Division) "Waterlilies and Butterflies" (watercolor on silk), Wei-Ping Loh, M.D., Gary

#### Class I—Oil

First "The Clown," Mrs. Richard Schumacker  
 Second "Barbarian," Mrs. Boyd K. Black  
 Third "Vineyard in the Alps," Mrs. Garvey Bowers  
 Honorable Mention "Chez Moi," James M. Donahue, M.D.

#### Class II—Acrylic

First "Look What Grew in the Woods Last Night," James M. Donahue, M.D.

#### Class III—Watercolor

First "Waterlilies and Butterflies"  
 Second "Up in Michigan," James M. Donahue, M.D.  
 Third "Portrait," W. P. Loh, M.D.

#### Class IV—Pastel

First "Young Man," Mrs. Boyd K. Black  
 Second "Winter Scene," Paul G. Iske, M.D.

#### Class V—Batik

First "Balloon Boy," Mrs. Robert Brubeck  
 Second "Man with Beard," Mrs. Robert Brubeck  
 Third "Girl with Flowers," Mrs. Robert Brubeck

#### Class VI—Photography

First "Corregidor Today," Leo Kammen, M.D.  
 Second "Safe Waters," Robert E. Hannemann, M.D.  
 Third "Nose to Nose," Harry Siderys, M.D.

#### Class VII—Sculpture (wood)

First "Soaring," Boyd K. Black, M.D.

#### Class VIII—Crafts

First "Candle Mystery," Mrs. Virgil Graber (pottery)  
 "Plate and Goblet," Mrs. Jack Mershon (zebra wood)  
 Second "Butterfly," Mrs. Harold Halbrook (papier mache)  
 Third "Hanky Panky," Mrs. Virgil Graber (pill bottles)

#### Class IX—Collections

First Insect Collection, Delano Z. Arvin, M.D.

### SCIENTIFIC EXHIBIT AWARD WINNERS

**First Place:** Allan A. Katzberg, Ph.D., Indianapolis—Aesculapius Award, courtesy of Eli Lilly and Company—ACCELERATION OF WOUND HEALING.

**Second Place:** Charles M. Evarts, M.D., Kenneth E. DeHaven, M.D., Alan H. Wilde, M.D., Carl Nelson, M.D., H. Royer Collins, M.D., The Cleveland Clinic Foundation, Cleveland—INDICATIONS FOR TOTAL HIP REPLACEMENT ARTHROPLASTY.

**Third Place:** Leonard Gottesman, M.D., Cincinnati—TEN YEARS WITH PERMANENT PACEMAKERS IN A COMMUNITY HOSPITAL.



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# Minutes of the House of Delegates

1972

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# House of Delegates Proceedings

October 15, 17 and 18, 1972

## INDIANAPOLIS SESSION

The first meeting of the House of Delegates convened at 2:00 p.m., Sunday, October 15, 1972, in Room 210 of the Indiana Convention-Exposition Center, Indianapolis, with Dr. Peter R. Petrich, president of the Indiana State Medical Association, presiding.

The second meeting of the House was convened at 9:00 a.m., Tuesday, October 17, in Room 210 of the Indiana Convention-Exposition Center, and the final meeting was held at 9:00 a.m., Wednesday, October 18.

Dr. Donald M. Kerr of Bedford gave the invocation at the first meeting of the House.

### Report of Credentials Committee

Dr. Arvine G. Popplewell, chairman of the Credentials Committee, reported 106 delegates, 13 alternate delegates, 4 officers, 14 trustees, 7 alternate trustees and 9 past presidents in attendance at the first meeting. The chair announced that, inasmuch as 50 constitutes a quorum, there was a quorum present for the first session of the House of Delegates. Attendance at the second meeting was 106 delegates, 8 alternate delegates, 4 officers, 13 trustees, 8 alternate trustees and 6 past presidents. At the last meeting the attendance was 114 delegates, 9 alternate delegates, 4 officers, 14 trustees, 9 alternate trustees and 8 past presidents.

### In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1971 annual session. The House stood in memory and tribute to the following:

OTTO H. BAKEMEIER,  
Indianapolis

DAVID A. BICKEL,  
South Bend

GEORGE S. BOND, Indianapolis

LESTER D. BOROUGH,  
South Bend

ERNEST R. CARLO,  
Fort Wayne

ALBERT J. CREVELLO,  
Evansville

AMADEO F. GREGOLINE,  
Gary

ROBERT F. HARRIS,  
Noblesville

DAVID R. JOHNS, Beloit, Wis.,  
formerly East Chicago

HARRY E. KITTERMAN,  
Indianapolis

KARL M. KOONS, SR.,  
Indianapolis

WILLIAM M. LOEHR,  
Indianapolis

JAMES S. McBRIDE,  
Indianapolis

LYMAN T. MEIKS, Indianapolis

WILLIAM C. MOORE, Muncie

ELMER B. MOSER, Windfall

RALPH R. PLOUGHE, Elwood

NELSON H. PRENTISS,  
Oteen, N.C.,  
formerly Fort Wayne

HECTOR S. QUIAMBAO,  
Ridgeville

HENRY H. REEDER,  
Jeffersonville

RUSSELL A. SAGE, SR.,  
Indianapolis

FRANK E. SAYERS,  
Terre Haute

E. ROGERS SMITH,  
Indianapolis

REUBEN A. SOLOMON,  
Indianapolis

GEORGE A. THEGZE,  
East Chicago

FRANK THOMPSON,  
Columbia City

JAMES F. TREON, Aurora

HAROLD M. TRUSLER,  
Indianapolis

The name of Dr. Paul J. Bronson of Terre Haute, was listed in error as deceased. The following resolution was introduced by Dr. Wilbert McIntosh, Trustee of the Fifth District, which was accepted by consent:

WHEREAS, ISMA has seen fit to consider Paul Bronson among the deceased members; and WHEREAS, Paul Bronson, though retired from medical practice, continues his vigorous behind-the-scenes activity toward the public and private health of Vigo County citizens; and WHEREAS, he, like Mark Twain, will appreciate the irony of all this;

THEREFORE, BE IT RESOLVED that ISMA congratulates Dr. Paul Bronson for his 50 years of energetic activity on behalf of this organization and compliments him for outliving his membership in this organization.

### Approval of Minutes

The proceedings of the 122nd annual meeting of the House of Delegates held in Indianapolis, Indiana, and published in the December 1971 JOURNAL of the Indiana State Medical Association were approved upon motion duly made, seconded and carried.

### Introduction of Guests

The president introduced Drs. John H. Budd, Raymond T. Holden, Max H. Parrott, James H. Sammons and Donald E. Wood, AMA Trustees; Dr. Frank J. Jirka, president, Illinois State Medical Society, Dr. L. C. Hess, president, Kentucky Medical Association; Dr. William R. Schultz, president, Ohio State Medical Association; Dr. Worthy W. McKinney, president, West Virginia State Medical Association; Donald L. Taylor, executive secretary of the Iowa Medical Society; Earl R. Thayer, Secretary, State Medical Society of Wisconsin; Peter Mathew of Zurich, Switzerland, an exchange student, and Mr. Robert Barnes, secretary, and Mr. Breck Lebeque, treasurer of the Indiana Chapter of SAMA.

### Recognition of Dr. Herman Baker of Evansville

Doctor Petrich gave recognition to Dr. Herman Baker as the oldest living past president of Indiana State Medical Association. Doctor Baker served as president in 1938.

### Dr. Otis Bowen Addresses the House of Delegates

Doctor Bowen, Republican candidate for Governor of Indiana, addressed the House of Delegates, outlining his platform, and answered questions from the delegates.



## Address of the President

### HOUSE ACTION: Ordered filed.

Thank You, Dr. Gosman, Officers of the Association, members of the House of Delegates, ladies and gentlemen, colleagues and friends.

I shall attempt to be as brief as possible in my address, in view of the fact that the changes proposed relative to streamlining the Convention included an attempt on my part to have most of the reports in a written fashion in the hands of the officers and delegates in an adequate amount of time prior to the Convention. This was to enable everyone to review, at their leisure, those reports and informational items so that they would be better able to discuss them when the time came in the Reference Committees and in the actions of the House of Delegates. I, therefore, have distributed to all of you a written report of recommendations as a result of my year as president of your organization. Whether the attempts to streamline the Convention will be successful remains to be seen at the conclusion of this Convention. I am sure that the Sub-Committee of the Board and the Commission on Convention Arrangements will review the many facets of the Convention and determine whether the changes in the program have been appropriate.

There are, however, several things that I would like to talk about at this time. On the basis of recommendations from the Commission on Public Information, from our own executive secretary, from previous presidents, and in my own printed list of recommendations, we have talked about improvement in public relations and communications. The basic communication of Indiana State Medical Association to its member physicians has been one that has been extremely deficient over the years.

I have an idea that the members of the House of Delegates, in addition to the Society officers and the Board of Trustees, can serve in a purposeful way to help improve the communications of the ISMA to its member doctors. This could be accomplished by having, for example, all informational materials (rather than being sent to the doctors directly and placed almost invariably in file 13) sent to the members of the House with the notation "this material is important and is to be brought up to the membership of your county societies at your next regular society meeting." In that manner, we could perhaps then have a direct reporting of physicians to

physicians regarding the activities and the needs of organized medicine.

We can also educate our physicians, through all of you, to inform our medical assistants and office personnel that, when materials labeled "Indiana State Medical Association" or "Medical Association Business" make an appearance at the office, these are to be referred directly to the physician so that at some time when he has a brief spare moment, he would have an opportunity to look over those materials. When the doctors are informed, we can't help but have better input into the control of the changes that people are attempting to foist upon us and *it is essential that we have input into the controlling mechanisms.*

The next item I would like to mention to you has to do with another word ending in "ion" and that is dedication. Many of your colleagues are extremely dedicated to the causes of organized medicine as representatives of the physicians of our organization. There are, unfortunately, some people who choose to accept roles, positions and duties in organized medicine who then fail to follow along in a total dedicated way. If you are going to be active in organized medicine, then be sincere in your endeavor. Work as hard within the limits of your practice, families and time, as you can to accomplish the goals that you set for yourself or that are set for you. The days of honorary elevation to important positions in State Medicine are long past. If someone asks you to do a job, and, after an examination of your circumstances, you decide that you cannot possibly do it to the maximum benefit of yourself and your colleagues, then it is most important that you say so, so that a substitute who can do the job may be found. It is a trying experience to attempt to establish Commissions and Committees of varying kinds over a period of months and end up with a small percentage of the number of acceptors literally doing most of the work.

There are many problems that we face that are very very important, as you all know. We are plagued with government intervention into the affairs of the delivery of health care, and the government seems to be doing more and more with less and less results at greater cost. We need government for many obvious reasons *but*, when it insinuates itself in areas of no expertise, the results can be and often are chaotic—witness the results of government interference in the delivery of health care to our aged and indigent, Medicare and Medicaid. The fantastic expenses needed to support the bureauc-

racy have resulted in reduced services to patients and greater personal outlay of dollars by the people who were to be better served. We must make a total commitment to do all that we possibly can to prevent this from happening via a national health insurance program or other health care legislation now pending before the Congress. We must reiterate the cause and success of the present system of health care and decry the so-called crisis in health care for what it is—a political myth.

*But* we must also present viable alternatives. We have to work to improve the areas of care that need improving. We should be objective enough to see, evaluate and correct what inadequacies and problems we uncover and we should work through our existing organization to accomplish these goals—primarily, the Indiana State Medical Association.

Our commitments involve a resort to politics and politicians, a resort to influencing legislation through our physician-patient personal encounters. We should use any and all mechanisms and spheres of influence that are available to us or become so. There is no way that we could justify abrogating our responsibilities to our patients to any third parties under the guise of social reform for improving the health of the United States citizenry.

I heard someone talking about post-graduate education as it related to physicians. This individual, himself, an academic physician, used the analogy of airplane pilots who require additional training to move up the line from small planes to larger propeller planes, from small jets to larger jets, to the jumbo jets. The thought struck me that the analogy was incongruous, and I could just see two doctors meeting in the hall of the hospital with Charley saying to Joe, "Have you flown any good patients lately?" That's ridiculous but no more ridiculous than anyone drawing an analogy between a technical craft and the art and science of Medicine.

Medicine is the most humane of the sciences and the most scientific of the humanities. We must keep it so. It is up to each and every one of us to do all in our power to preserve the system of Medicine by improving it and making it more and more appropriate to the needs of our patients.

It has been a very busy and fruitful year. From my standpoint, great benefits have been derived by me because of my being president of your organization. I only hope that in some small way my



being president has been beneficial to all of you.

## Printed Report of the President

**HOUSE ACTION:** Approved with exceptions of items 3, 5 and 6. Ordered filed.

**Item 3. — Recommendation of Reference Committee** that the immediate past president should not be a member of the Executive Committee but should be a member of Board of Trustees without a vote. Referred to Commission on Constitution and Bylaws.

**Item 5. — Reference Committee** endorsed the efforts in streamlining the convention but felt that extending the convention by one day is not in keeping with a "streamlining program."

**Item 6. — Reference Committee** felt it unfair to divert all the money for AMA-ERF to one specific program.

### ITEM 1

I would like to commend the activities of the Committees and Commissions of the Indiana State Medical Association during the years 1971, 1972. As is well-known, the president and president-elect this year attempted to make some changes in the activities of Committees and Commissions and in their structure. The changes that were attempted were primarily in two areas. One, to instill the idea of independence in activity with a report with the Board of Trustees regarding the activities of Commissions and Committees and to make the functions of the Committees and Commissions more meaningful by reducing the number for a quorum to those members present. This has worked out admirably during the past year with few exceptions. For the most part, the members of the Committees and Commissions made an unusual attempt to be present at meetings and to be participants and to engage in activities of the Committees and Commissions. In those meetings of Committees and groups in which there were a smaller number of people present, the functions of those Committees and Commissions were able to be continued.

### ITEM 2

In line with the above and with those attempted changes which have apparently been, to a more or less degree, successful, I would like to propose that there be, in fact, a complete study of the activities of ISMA regarding their Committees and Commissions. The reason for proposing such a study is that I feel a revision of the operative functions of some of our Committees and

Commissions is in order. For instance, the Commission on Medical Economics and Insurance and the Commission on Governmental Medical Services have at times during the past years studied similar problems with different resulting conclusions. At other times, after parallel study, they have reached the same conclusion. A single group could incorporate the expertise of both groups into one. I would propose that it might benefit our organization better if a Commission on Socioeconomics were to be founded incorporating the activities of these two Commissions. Our Commission on Inter-Professional Relations has not been as active as one might hope it should be. Its activities have been taken over, in part, by other Committees of our organization—such as the Committee on Medical-Legal Review and the Committee on Medicine and Religion. It might be appropriate to streamline and incorporate the activities of these particular committees into a Committee on Inter-Professional Relations which would then have a different point, a different direction, and perhaps a different organizational structure. At any rate, no conclusion can be reached immediately without some form of a review and study of our Committees and Commissions structure on the part of Indiana State Medical Association. I would not burden the House of Delegates nor the Reference Committees with a method of operation regarding this review and revision. I would only urge that such review be undertaken.

### ITEM 3

As has been mentioned more than once, the activities of the president of the Indiana State Medical Association are hectic in the year before he becomes the president; are absolutely impossible during the year of his presidency and, at the conclusion of the state meeting in October, the president becomes a very past figure. I feel that the invaluable experience that the individual acquires in assuming the presidency of such an organization as ours is worthy of some continued use. I would make a proposal that the immediate past president be a member of the Executive Committee of the Indiana State Medical Association. I would also recommend that he be an *ex officio* member of the Board of Trustees with full right of discussion for the one year succeeding his term as the president of Indiana State Medical Association. The first recommendation comes about because of the potential and usual changes that take place in the makeup of the Executive Committee. There have

been times when only one or two members of this Committee have been holdovers or repeat members, so that an educational process by this small number of a large number is necessary. I maintain that the position of the president of Indiana State Medical Association has given the individual several years of experience in dealing with the matters that come before the Executive Committee and holding a position as a member of the Executive Committee for one year would be entirely within the purview of that individual, and would be in order for the Indiana State Medical Association. As regards the presence of the past president at the Board of Trustees meetings, the same arguments hold forth. I feel that this individual should *not* have the right to vote at the Board of Trustees meetings, but *should* have the right of discussion as is granted to most of the members of the delegation to the AMA and their alternates, and to the alternate trustees to the Board of Trustees.

### ITEM 4

I would propose that the Commission on Constitution and Bylaws immediately institute a change in the Bylaws which would allow for the election of the officers of the state association at the last meeting of the House of Delegates rather than on the last day of the meeting, as it now is written. This would allow the president and other elected officers of the association to make whatever arrangements would be appropriate regarding elections and the organization of the meeting without other major changes being made. The meeting in October 1972 has been greatly changed, as you are all aware. The efficacy and success of such change will not be made aware to us until it has become history. If it is indeed successful, then this recommendation becomes paramount to allowing the officers latitude in making adjustments.

### ITEM 5

I would commend especially this year the Convention Arrangements Committee which has worked so well with the Board of Trustees and its sub-committee on streamlining the Convention to make changes as you see them and have experienced them or will experience them. In my term as president I have been privileged to attend the meetings of many of our surrounding states during this time. It has been my experience that there is a great deal of difference in organization of the other state meetings, both scientific and socioeconomic. I would, therefore, recommend that the chairman and/or a representative member of the Con-



vention Arrangements Commission be empowered and urged to attend, during the year, for at least one day the state meetings of our contingent states. This would, in effect, give us a broad base from which to garner ideas and make changes for the better that would improve our attendance at meetings and make for a more appropriate annual state meeting. The Scientific Assembly Council of the American Medical Association should also be contacted and met with by representative members of our Commission on Convention Arrangements on an annual basis, to enlist any aid that we might be able to get in those particular areas.

ITEM 6

I would propose that in Indiana, where a major thrust in our activities and our aims in medical education has been in the fields of primary care physicians, we consider the position of our funding of AMA-ERF. In times past this money has been shunted through the Medical Education Foundation which has made various appropriations and allocations to the Indiana University School of Medicine. These monies, by and large, have not gone for education and funding of training primary care physicians. I would propose that in Indiana we earmark the Indiana State Medical Association's monies for AMA-ERF to be used only in establishment of training programs or in the actual education of primary care physicians. The primary care physicians would be family practitioners and pediatricians.

ITEM 7

It has been our experience during the course of the year (the president-elect and I), that most of our member physicians feel that we have been derelict to some degree in promoting the image of the Indiana physician. I would propose to you, as has been proposed to you several times by divers people, that a budgeted item, not miniscule or insufficient, be made annually to perform the functions of adequate public relations. Only through the selling of the physicians of Indiana; what our position is, what our goals are, what our attitudes toward health care are, can we inveigle enough public support to accomplish those things that we would like to have accomplished.

ITEM 8

I would propose a review of the programs of the Indiana State Medical Association as they apply to the individual members of our association. By this I would mean the programs that we have

in the leasing of cars, the disability insurance, life insurance, the travel program, what-have-you. I would assume that there are, indeed, other areas that we might look into that would be of benefit to our membership, such as mass buying outlets and retirement programs. I believe that we must have a mechanism for regular review of this particular kind of personal service to the membership of ISMA.

ITEM 9

I propose that a change be made in the section of the Bylaws Chapter 30 dealing with Reference Committees (Section 1, Paragraph 3). Each Committee shall consist of five members at least three of whom, etc. The proposed change that I would make in the Commission on Constitution and Bylaws is to further enhance the ability of the president to appoint a Reference Committee that will be one that would be learned and receptive to the membership at large which appears before it to testify. The change would be the insertion of the words "at least" before "five members." The president has assumed, as the chairman of the Convention, the right to appoint more than five members to each of the Reference Committees at the present meeting of the Indiana State Medical Association, hoping that there is no objection. The reason for the expansion of the Reference Committees is to allow a more diverse membership of the Reference Committees by geographic socioeconomic practice levels and to allow for greater input of ideas by a somewhat larger group of individuals than has occurred, perhaps, in times past. The success or lack of success of such an arrangement will certainly be obvious to the House of Delegates by the time the reports of the Reference Committees are heard during the October meeting in Indianapolis.

ITEM 10

I would again espouse the cause, as I have on many occasions in the past, of having the Indiana State Medical Association become intrinsically, directly, irrevocably and totally involved in a computer processing program within the confines and the structural organization of ISMA. I feel, as I have for a long time, that computers are an essential part of the future of medicine in many guises. I feel that we have been moderately up-to-date in maintaining our education regarding these computers, but we have, in fact, been somewhat behind times in instituting any changes that would bring about the actual use of and perhaps in-

stallation and functioning of computers within the state structure, both physically and philosophically. It is a subject that is worthy of immediate consideration on the part of the State Medical Association and should not be deferred to any study committee without specific charges made by the House of Delegates. If we do not make a single substantive effort to accomplish some major involvement of our organization in these particular kinds of programs, then I feel that we will leave to lay individuals, however technically qualified they may be, the total business of medicine, when it relates to computers. And more and more of medicine is being related. I urge, sincerely, a consideration of this proposal.

PETER R. PETRICH, M.D.

Remarks of President Petrich

Any delegate may introduce a resolution from the floor, provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session in the rear of Room 210.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this Association.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as



properly come before the Board, and the recommendations of these committees shall be submitted at the second meeting of the House of Delegates at 9:00 a.m., Tuesday, October 17, for acceptance in the original or modified form, or for rejection. The Tuesday morning meeting will be held in Room 210 of the Convention Center.

Each reference committee consists of seven (7) members; the first member named is chairman. Will committee members please stand as their names are called?

#### REFERENCE COMMITTEE NO. 1

Arvine G. Popplewell, Indianapolis (Marion) *Chairman*  
T. Neal Petry, Delphi (Carroll)  
James D. Finfrock, Elkhart (Elkhart)  
Robert M. Brown, Marion (Grant)  
Lowell W. Painter, Winchester (Randolph)  
Robert A. Hedgcock, Frankfort (Clinton)  
Bernard B. Rosenblatt, Evansville (Vanderburgh)

#### REFERENCE COMMITTEE NO. 2

John D. Wilson, Evansville, (Vanderburgh), *Chairman*  
Howard C. Jackson, Madison (Jefferson-Switzerland)  
Edwin S. McClain, Indianapolis (Marion)  
James S. Fitzpatrick, Portland (Jay)  
Max N. Hoffman, Covington (Fountain-Warren)  
William Grosso, East Chicago (Lake)  
George M. Haley, South Bend (St. Joseph)

#### REFERENCE COMMITTEE NO. 3

Donald R. Taylor, Muncie (Delaware-Blackford), *Chairman*  
Marvin L. McClain, Scottsburg (Scott)  
Harry R. Baxter, Seymour (Jackson-Jennings)  
Joseph W. Young, Greenwood (Johnson)  
George M. Underwood, Lafayette (Tippecanoe)  
Walfred A. Nelson, Gary (Lake)  
Donald G. Mason, Angola (Steuben)

#### REFERENCE COMMITTEE NO. 4

Betty J. Dukes, Dugger (Sullivan), *Chairman*  
David H. Jones, Charlestown (Clark)  
Fred W. Dierdorf, Terre Haute (Vigo)  
Frederick H. Evans, Indianapolis (Marion)  
Eugene T. Karnafel, Logansport (Cass)

Thomas G. Hamilton, Columbia City (Whitley)  
Guy B. Ingwell, Knox (Starke)

#### REFERENCE COMMITTEE NO. 5

Thomas C. Tyrrell, Hammond (Lake), *Chairman*  
Louis H. Blessinger, Corydon (Harrison-Crawford)  
William Anderson, Bloomington (Owen-Monroe)  
C. David Ryan, Columbus (Bartholomew-Brown)  
Tom S. Shields, Richmond (Wayne-Union)  
Donald M. Schlegel, Indianapolis (Marion)  
DeWayne L. Hull, Fort Wayne (Allen)

#### REFERENCE COMMITTEE NO. 6

Wilson L. Dalton, Shelbyville (Shelby), *Chairman*  
L. John Vogel, Mt. Vernon (Posey)  
Thomas J. Conway, Terre Haute (Vigo)  
Charles E. Test, Indianapolis (Marion)  
R. Adrian Lanning, Noblesville (Hamilton)  
Fred C. Poehler, LaFontaine (Wabash)  
Charles O. Hamilton, South Bend (St. Joseph)

#### REFERENCE COMMITTEE NO. 7

Martin J. O'Neill, Valparaiso (Porter), *Chairman*  
John H. Barrow, Dale (Spencer)  
Glen McClure, Sullivan (Sullivan)  
Fred E. Haggerty, Greencastle (Putnam)  
I. E. Michael, Indianapolis (Marion)  
Jeff H. Towles, Fort Wayne (Allen)  
John W. Luce, Michigan City (LaPorte)

#### SPECIAL REFERENCE COMMITTEE

Lowell H. Steen, Hammond (Lake), *Chairman*  
Hugh K. Thatcher, Jr., Indianapolis (Marion)  
Gilbert M. Wilhelmus, Evansville (Vanderburgh)  
John W. Beeler, Indianapolis (Marion)  
Jack M. Lockhart, Connersville (Fayette-Franklin)  
Earl R. Leinbach, Hamlet (Starke) At Large  
Richard D. Hawkins, Bedford (Lawrence) At Large

#### TELLERS

Lowell W. Painter, Winchester, *Chairman*  
Bernard B. Rosenblatt, Evansville  
Robert A. Hedgcock, Frankfort

## AMA Delegates and Alternate Delegates

The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1974:

Delegate, James A. Harshman, Kokomo; alternate, A. Alan Fischer, Indianapolis; delegate, Eugene F. Senseny, Fort Wayne; alternate, Ross L. Egger, Daleville; delegate, Malcolm O. Scamahorn, Pittsboro; alternate, Kenneth O. Neumann, Lafayette.

## Resolution Concerning Frank H. Green, M.D.

The following resolution from the Indiana AMA Delegation was read by Dr. Eugene F. Senseny.

WHEREAS, Frank H. Green, M.D. has served with distinction in the AMA House of Delegates for 10 years, and

WHEREAS, the State of Indiana and more especially the ISMA has been fortunate to have the caliber of man he has been, and

WHEREAS, his wisdom and counsel will be sorely missed,

THEREFORE BE IT RESOLVED, that this House show true tribute to his sacrifice and the giving of himself in this area of responsibility by inscribing our gratitude in the records to both him and his gracious and charming wife, Jean, and

FURTHER, BE IT RESOLVED, that this House immediately express this by a thundering round of applause for both of them.

## Selection of City for 1977 Meeting

Dr. Joe Dukes, chairman of the Board, recommended Indianapolis for the 1977 meeting. Motion duly made, seconded and carried. Dates to be decided at a later time.

## Report A—Board of Trustees

Regarding Resolution No. 71-3, DECLARATION OF NON-PARTICIPATION POLICY

**HOUSE ACTION:** Resolution 71-3 as included in Report A of the Board of Trustees and Resolution 72-19 were considered together. The resolutions were combined and substitute Resolution 72-19A was adopted as amended, in lieu of Resolution 71-3 and Resolution 72-19. The portion of the original Resolution



72-19, dealing with funds, was referred to the Board of Trustees for further study and possible action and report back to the House in 1973.

## Resolution No. 72—19 A

WHEREAS the free enterprise, fee for service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor, and

WHEREAS Government intervention between the practicing physician and the patient historically removes responsibility from both parties and leads to decreasing quality of medical care, and

WHEREAS the current proposals for federal regimentation of medical care which are before the congress (Senate Bill 3 and H.R. 7741) will result in total control of all patients and all doctors, with no free choice alternative, and

WHEREAS the members of the Indiana State Medical Association wish to continue to provide medical services in the most efficient manner, retaining freedom of choice for physician and patient alike, and retaining mutual respect and responsibility between patient and physician; and

WHEREAS no plan of socialized medicine or other form of government sponsored health care plan can function without cooperation and participation of the majority of the physicians of the involved community;

THEREFORE, BE IT RESOLVED that ISMA notify members of Congress and the public that we will continue to actively work for enactment of legislation supporting fee for service, the traditional patient-doctor relationship, state licensure of medical practitioners, voluntary relocation of physicians, the right of privileged communication between the patient and his doctor, and the institution of voluntary review of requirements.

BE IT FURTHER RESOLVED that a fund be set aside from a \$3.00 per member increase in dues to provide adequate legal counsel for class action suits to stop implementation of economic regulations which apply in a discriminatory fashion to physicians, and also to provide for legal defense for all members of Indiana State Medical Association who come under criminal prosecution for violation of any of these regulations.

## Amendments to the Constitution

### HOUSE ACTION: Adopted.

THEREFORE, BE IT RESOLVED, to amend Article V of the Constitution by

adding an additional paragraph after the first paragraph to read as follows: "All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation."

## Election of Officers

OFFICERS: Dr. James H. Gosman of Indianapolis assumed the office of president and Dr. Joe Dukes of Dugger, was elected president-elect.

Dr. Hugh K. Thatcher, Jr., Indianapolis, was elected treasurer by acclamation.

Dr. Arvine G. Popplewell of Indianapolis, was elected assistant-treasurer by acclamation.

Dr. Gilbert M. Wilhelmus, Evansville, was elected chairman of the Board of Trustees. Dr. Donald M. Kerr, Bedford, was re-elected chairman of the Executive Committee and Dr. Vincent J. Santare, Munster, was elected a member of the Executive Committee.

## Election of Trustees

Four new trustees elected in 1972 were: Dr. Paul W. Holtzman, Bloomington, Second District; Dr. Cleon M. Schauwecker, Greencastle, Fifth District; Dr. Joseph F. Ferrara, Franklin, Seventh District; and Dr. James A. Harshman, Kokomo, Eleventh District. Dr. Richard G. Ingram, Montpelier, Eighth District, was re-elected. Dr. Howard C. Jackson, Madison, Fourth District, was elected to fill the unexpired term of Dr. Jack Shields, who resigned.

Newly elected alternate trustees were Drs. Donald McCallum and John G. Pantzer, Indianapolis, Seventh District. Dr. William F. Blaisdell, Seymour, Fourth District, elected to fill the unexpired term of Dr. Howard C. Jackson, Madison. Dr. William G. Bannon, Terre Haute, Fifth District, elected to fill the unexpired term of Dr. Cleon M. Schauwecker, Greencastle. Dr. Glen Ward Lee, Richmond, Sixth District, elected to fill the unexpired term of Dr. Paul M. Inlow, Shelbyville. Dr. Jack Alexander, Muncie, Eighth District, to fill the unexpired term of Robert D. Williams, Anderson, who resigned. Dr. Lloyd L. Hill, Peru, Eleventh District, to fill the unexpired term of Dr. James A. Harshman, Kokomo.

## Address of President-Elect James H. Gosman

### HOUSE ACTION: Ordered filed.

Mr. President, members of the 1972 House of Delegates of Indiana State

Medical Association, guests and friends of medicine:

One year ago you elected me to serve as your president-elect and within a few days the reality of serving as your president will be upon me. I have attempted to project myself into that moment of truth but find it extremely difficult at this time. I only know medicine is at a crossroad and despite the questions asked of me about why I should want to devote the time, effort, and personal energies at this particular time of life, I can only say I am most willing to accept the challenge. I will look back some day and be able to say I was in the thick of the problems at the time of change. Believe me, I have no illusion that I am going to solve all questions. In this position as president, one never gets to see the fruits of his success or failures until years later.

At this stage in our process no one is more fully cognizant of the fact that I am only one small cog in an organization of which I am most proud to be able to say, "I am a member of the honored profession of medicine" and therefore I am given the privilege of being a member of my county, state, and national organizations and can therefore engage in the decisions that are to be made.

During the past year it has been my good fortune to get to know Dr. Petrich and his family. It is not my intent to detract from past-presidents, but it is my firm observation that Dr. Petrich has taken giant strides to merge us into the solid, hard-working dedicated organization that I have always visioned we should be and without which we cannot possibly survive. We owe him a real debt of thanks. My teacher has been an excellent one and I promise that the features started by him will not die in limbo. I would further suggest that the talents demonstrated by Dr. Petrich not be allowed to fade into oblivion but to harness them for the future of our state and national organizations.

At this point it is no doubt customary for one in this position to mention all the great new plans he has for the future, to solve all problems so that we may go home resting assured all is well. Or, perhaps, it is incumbent upon me to deliver some stirring oratorical masterpiece in order to whip everyone into a state of combative spirit. This would almost reflect seniority by senility. One should not plan on preparing a fruit salad when all the government and HEW are providing is lemons.

If everyone would read the reports of the executive secretary, the Executive



Committee, the Board of Trustees, the reports of committees and commissions, he would have a working knowledge of what has been accomplished, what is being suggested, and what has been investigated by dedicated colleagues representing hours and hours of hard work. I am most proud of these members, since they are the ones that really do the work and upon whom we must depend for many of our decisions.

As I have conveyed at several district meetings, I am not as pessimistic as some about the future of medicine. The nation's real problems of medical care can best be met by measures that focus on particular trouble areas rather than a violent transformation of the entire complex medical system that would affect equally all parts—those working well and those working poorly.

Medical care in Indiana does not present the broad problems as envisioned in other areas of the country. We, the physicians in Indiana, can solve these problems. Great strides have already been made; and given a little more time we, along with our colleagues, can meet the challenge in this state. I would list those most pressing items for consideration as follows:

(1) Distribution of physicians and medical care in rural and urban areas. (In this we must be the leaders.)

(2) Public relations and communication with grass roots—public and physician. (Our major theme should be what is happening to America.)

(3) Problems surrounding the third-party insurance companies. (Everywhere we visited, this was always the major item for discussion.)

(4) Medical Liability.

(5) Cost of medical care along with quality of medical care.

It is suggested you familiarize yourself with the supplemental report prepared by me.

I would like to end with this short prayer:

God grant me the serenity to accept those things I cannot change—courage to change the things I can—and wisdom to know the difference.

## Supplemental Report of the President-elect

**HOUSE ACTION: Adopted. Recommendation that interns and residents have a separate section and send a voting delegate to the House be referred to the Commission on Constitution and Bylaws. Consideration be given to the creation of a Section on Faculty Physicians be**

## referred to the Commission on Constitution and Bylaws.

To unite is to blend together and in medicine it is the melting of components of the profession into a singleness of purpose. And so I ask that you, the members of the Indiana State Medical Association, join with me to forge the strongest bond possible. The risks are becoming more and more apparent as medical specialization and its concomitance in medical education and hospital care generate friction between full time and salaried staffs and the private practitioner.

It is not uncommon to hear reference made to the splintering effects of specialty organizations on the whole of medicine. The fact that a physician has decided to continue his education in a specialized field is indicative of this—his interest. Therefore, it is only natural for him to affiliate with a specialty organization, to attend its local, state and national meeting, and to participate in the formulation of its policies. The impact of this divided allegiance between the local county medical society and the specialty organization often is quite apparent. In many instances this divided allegiance deprives the county medical society of capable leaders who should be sharing their talents.

Proficiency in the science of medicine is not enough. Medical knowledge must be applied skillfully and sympathetically to every patient. Moreover, every physician must be cognizant of, and interested in, the socioeconomic impact of illness upon his patient and the community in which he lives, as well as the potential effect of government-sponsored programs on the practice of medicine.

I appeal to those of you who represent specialty organizations, to the individual specialists, to the general practitioner, to those in administrative medicine and in government service, and to medical educators, to impress upon your colleagues and members that, if medicine is to serve the public in the future to the high degree it has in the past, it must be united, stand firm and strong, with a heart and conscience tuned to the public need, with a respect for the rights and privileges of the individual and with an abiding faith in our free, competitive system of medical practice.

The technique of divide and conquer has been used successfully in many areas. There are those who exploit every opportunity to divide the Medical Association. We must not permit this to happen. I ask each of us, no matter what his field of practice, to take part in the

activities of the Indiana State Medical Association and the American Medical Association.

Those remarks were made by me in September of 1965 as part of the President's Page of the Marion County Medical Society Bulletin. It is obvious to me, and it should be to you, that this expression is even more important today than it was back in September 1965.

It has been an extreme pleasure to serve as your president-elect during the past year. Having observed Dr. Peter Petrich, our president, during the last year, I feel I am definitely in a better position to continue on as your president. I hope that I will be worthy of that high office.

During the past year Dr. Petrich and I have tried to visit each and every one of our district meetings. We almost made it 100%; but, because of American Medical Association meetings in other sections of the country, it was impossible for us to attend two district meetings. One of these district meetings, however, was somewhat made up by a second visit to the area upon the request of the trustee. I feel that this has been most beneficial to me and I definitely plan to continue the program next year.

It again is imperative that our commissions and committees, whose work is most important to our organization, must begin early after the new fiscal year, which is next week. Therefore, I have been busy trying to fill all vacancies in these committees and commissions. It is also my intent to meet with the chairmen of the committees and commissions this week so that we can begin our work without any hitches. It was my pleasure during the past year to attend most of the committee and commission meetings and I find that these members of our organization are hard-working and dedicated people who deserve our utmost thanks.

At this point I would like to comment very briefly upon the many items facing us. Our membership has continued to show a slow but steady growth; however, the membership in the American Medical Association has not shown the same growth but has instead shown some loss. Great effort has been made to obtain the names of those not belonging to the Association and again attempting to make them see how important it is for them to belong under one solid roof. Those physicians holding teaching positions at our School of Medicine should again be asked to give every consideration to belonging to our State and American Medical Association. The in-



put by the American Medical Association and the legislative activities of our own State Medical Association and the American Medical Association concerning the granting of funds to the university medical schools should be one very important reason for their membership. There have been occasions when we have wanted to appoint members of the medical school faculty to a committee in Washington which might have very easily brought about additional funds to our medical school, but it was impossible to do this because the person in question was not a member of the American Medical Association. There has been a suggestion made to me that perhaps we should even consider a separate section of members of our medical school faculty with representation at our House of Delegates.

A recent survey done by the State Medical Association points out the fact that we need to do more in the area of bringing the intern-resident physicians of the state into our County, State, and American Medical Associations. It revealed that there are nearly 500 interns and residents in Marion County alone. It would be my suggestion that this House of Delegates give consideration to establishing a separate section for interns and residents and that they be granted a delegate and alternate with a vote in the House of Delegates.

The Indiana State Legislature is now meeting yearly and, beginning with 1972, there are legislative committees meeting regularly who have a rather powerful agency that re-writes bills, numbers them, and sometimes selects the members of legislature who will introduce them. It is incumbent upon us to initiate year-round activities in the legislative area. The Board of Trustees has given permission to the executive secretary to employ a person to operate in this particular field and handle legislative matters. It is extremely important that the members of the legislative commission, as well as selected members from every commission and committee in the ISMA mechanism, be available to help in legislative decisions. It is becoming necessary for more physicians who are knowledgeable on specific legislation to devote their time and effort to legislative committee meetings and to express the views of the Indiana State Medical Association.

One of the most important and yet probably one of the most neglected phases of our program is public relations. We should be getting out to the very grass roots of the public, explaining to them the true facts and statistics about

every subject pertaining to medical care. The idea of taking some action in a public relations sense after a specific problem arises is antiquated and we should exert a continuing public relations effort. All media should be utilized in this pursuit. It is extremely important, I feel, that physicians take the time to appear before lay people and explain to them what is really happening to the United States of America and not just to the practice of medicine. Should we hire a public relations consultant? I further submit to you that it is time that we have a budget increase for public relations to be earmarked only for this specific use.

Our ISMA headquarters building has seen increased usage in the past several years and, because of many of the other activities in which I feel the Association should be involved, it is tremendously important that we give every consideration, from the standpoint of future planning and building committees, toward expansion of our building with increased and improved parking.

Mention and some brief consideration has been given to the fact that the State Medical Association could be handling billing, accounting and even tax services for members. With the advent and progress of the computer age this becomes even more of a possibility. When one considers the huge amounts of money each of us spend yearly on our billing, our accounting, and our tax service, I am sure this could be a very economical involvement if it were proved to be feasible and a large portion of our membership joined in such a program.

Despite the feelings of a great number of our organization, I feel that many of the governmental programs are staggering about and looking for medicine to really enter into and assist them out of the dilemma. We need only to look to some of our neighboring states, particularly Illinois, which is involved in handling some of these programs and problems for the state government. I firmly believe we should look seriously into this area of involvement. We have the medical knowledge and background to handle these problems rather than to delegate them to less knowledgeable people.

I would also hope that more of our specialty groups would continue to use the ISMA headquarters for assistance in any of their secretarial matters and in any other phase where they feel we can assist. It is my wish that the Sections will continue to take on the responsibility for the scientific presentations made at our annual meetings. We have

made a good start this year and I hope we can enlarge upon the involvement in the coming years.

Continuing medical education is going to be a very important subject for this House of Delegates. It, therefore, becomes even more important that our specialty groups and Sections join with us in these activities.

With the increase of computer technology during the past few years and with the presence in our own state of one of the finest computerized systems for assistance in the practice of medicine, I think it is necessary for us to look very closely into what use we can make of such procedures. The development in this area of history-taking, with the addition of certain laboratory procedures, can be extremely exciting. It can be one of the greatest assets in time-saving, health survey, storage and retrieval of very important medical knowledge that would not have to be repeated but simply brought up to date. The credit for this can go to two of our own members who have devoted a great amount of know-how and energy, let alone financing, to elevate the system to the point where it now stands. The American Medical Association has shown real interest, and I would wish the organization had been housed in our own State Medical Association building.

Another important development in the past year or two has been the Museum for Indiana Medical History. Our president has named a committee to work in conjunction with this museum. The site of the museum is the old Pathology Building on the grounds of the Central State Hospital in Indianapolis. All physicians in the state of Indiana will soon be asked to contribute any items that may be of historical significance to the practice of medicine in Indiana. We should be proud of this endeavor and support it with all our enthusiasm.

Funding for our continuing medical education program for physicians, externs, interns and medical residents under the Indiana Plan for Medical Education should be supported by the Indiana State Medical Association through our appropriate Legislative Commission. The Indiana Hospital Association, the Indiana University School of Medicine and the Directors of Medical Education have joined with us in promoting this particular legislation.

I would like to encourage the Woman's Auxiliary of the Indiana State Medical Association to give consideration toward holding their annual meeting at the same time the annual meeting of the



Indiana State Medical Association is held. I could envision greater participation, along with perhaps a saving of money, by holding corresponding programs at the same time.

Each year we hear of the increasing problems of the malpractice status in this state. For many years we have discussed this issue among ourselves, our local hospitals, with members of the insurance industry, and, yes, even members of the legal profession. There have been many ideas advanced in this field but none have jelled in any satisfactory answer. Even the President of the United States has been reported to be looking into the subject. At this time it seems we should become somewhat hard-nosed about this problem and really sit down and draw up some guidelines. I have some suggestions and I will present them to the Medical-Legal Review Committee.

Long hours have been spent by the Commission on Governmental Medical Services in regard to Medicaid, Medicare, and the involvement of the third-party payments in these two regions. The major problem appears to be interpretation of usual and customary allowances. This varies between different insurance companies, between physicians and different areas of the state. When we discuss usual and customary we are generally talking about that which has been determined by the "Blues." This House of Delegates has as yet not agreed upon the possible use of the relative value schedule in the state. It is my request that this House think hard and long about which way they want the State Medical Association to go. We are watching very closely the review program instituted by the Medical Association in the state of Illinois. It is still in its early phases but, in conversation with us, the president-elect of the Illinois State Medical Society seemed to feel it was promising.

We have got to arrive at some conclusions regarding the forming of a committee or commission for the purpose of reviewing third-party payments as well as claims questioned by the third parties. There is such a mechanism with the Blue Shield, through your district representative to the Board of Blue Shield; but, as far as I have been able to ascertain through our visits in the state, this mechanism in itself has not been working very well. I guarantee you that we are making every effort to correct this time-consuming and irritating situation.

It was my suggestion that, through the voluntary health agencies and our Commission on Voluntary Health Agen-

cies, the speakers for many of our scientific sessions could be procured through the voluntary health agencies. This would be a saving in money to the Sections and to this organization and I again recommend that the Commission on Convention Arrangements utilize this very good source of speakers.

The report of the Commission on Medical Economics and Insurance should be the hottest item for discussion at this House of Delegates. Here again, this commission has worked tremendously hard in trying to arrive at some satisfactory answers for our membership. Please read their report very carefully and be prepared to state your position to the review committee. This includes the setting up of foundations, so called peer-review committees, the handling of complaints, third-party payments, usual and customary fees, and all those problems which have taken up most of our time during the past year.

I have already commented on continuing medical education for our membership. I do feel that the Subcommittee of the Commission on Medical Education and Licensure should be maintained to aid in the implementation and maintenance of accreditation systems.

During the past year another Student-Faculty-ISMA Retreat was held. Report of this retreat appears in our journal and I would request everyone to familiarize himself with this report. I am happy to announce that over 50% of the recommendations made at this retreat have already been accomplished or will soon be accomplished. Our medical school has been most cooperative in this area, as well as many other areas, with your State Medical Association, and it is my desire that the Student-Faculty-ISMA Retreat be continued. A far greater understanding is being developed through such joint operations.

The Family Practice Preceptorship Program must be continued and enlarged, as well as improved upon. I know that the Section on Family Practice, as well as the chairman of the Department of Family Practice at the Indiana University School of Medicine, the medical directors, and many of our institutions are working diligently in this field.

The Commission on Special Activities was also busy this year and developed a two-day training institute which was hailed by the local community as a very successful venture. Since drug abuse is at this time of great importance to all of us, this commission will continue its

endeavors to inform, instruct and help us in every way possible. The Special Activities Commission appointed a subcommittee on rural health and, although only two meetings were held, it is my belief that great strides were made, and we hope to continue the work of this committee in cooperation with other programs along with our county medical societies so that cooperative measures to solve the need can be taken.

The ongoing activities of the Commission on Emergency Medical Service must be continued and expanded. We must pursue the bill which failed in the past legislature but which is of utmost importance. I believe better understanding is being had so that future legislation in some part or form will soon be passed. Additional meetings on the maintenance of helicopters, heliports and pads and the use of helicopters for emergency medical service must also be pursued.

The Commission on Aging did also consider those pressing problems of the convalescent patient leaving a hospital and having to make application to an extended care facility. They also became quite involved in all the many problems regarding frequency of visits, pay and other regulatory mechanisms. I heartily approve of all the recommendations made by this commission. I again point out that this commission also recommended that your State Medical Association provide for peer review for local medical societies to insure against abuses and to remove medical decisions from lay control.

I believe it is time this House of Delegates give consideration to the establishment of elected delegates from the Sections with the power to vote. I believe this would give continued and further involvement of many other members of our State Association.

During the period that the House of Delegates is not in session the Board of Trustees has the authority to act in its behalf. Members of the Board of Trustees are not confirmed by this House of Delegates and I would, therefore, recommend that steps be taken for the Districts to recommend to this House of Delegates their elected trustees and that they, in turn, be confirmed by this House, since they do represent the House of Delegates during the interim.

During our visitation to many of the district societies in our state, the question often came up as to why we are not offering the name of more than one person in nomination for president of our state organization. As I have watched other state medical associations function,



I have been impressed by the fact there has been a speaker and a vice speaker of the House of Delegates. These men are elected by you, the House of Delegates, and therefore are responsible to you. They have more opportunity to study and become professional at parliamentary procedure. They seem to be able to make a meeting of the House run more smoothly. They can appoint the reference committees. I would like to suggest that this would then give you the opportunity for exposure of additional people for consideration as president of your organization.

I would, finally, like to submit for the consideration of the House of Delegates the future use of past presidents of your organization. It has been my observation that a lot of time, money and effort is spent in developing a president of your organization, then suddenly he finds himself no longer needed or useful. It is my feeling this is a tremendous misuse of talent in many instances and that he should be retained in some capacity as immediate past president. There are arguments pro and con as to which would be the best place for him, but at this time I would suggest that he be a member of the executive committee with a vote.

### Remarks of Mrs. Philip L. Smith, President of the Woman's Auxiliary to the Indiana State Medical Association

#### HOUSE ACTION: Ordered filed.

Dr. Petrich, distinguished guests, members of the House of Delegates—I am here to report to you on the activities of the Woman's Auxiliary for this past year. First, however, I wish to thank Dr. Petrich, Dr. Gosman and Dr. Sholty, our advisor, for their interest and assistance with our programs. And a special word of thanks to Mr. Waggener, Mr. Bush, and the ISMA staff for their kindness and most helpful guidance.

In our 45th year we have a total membership of 2,596. This is a loss of about 100 members from the previous year; we are trying hard to gain the interest of all physicians' wives with meaningful programs—to enlist the support of the ladies in the areas of their greatest concern.

Our Health Manpower chairman has continued to promote recruiting of young men and women into medical and paramedical careers. Source material has been made available to schools through

local auxiliaries working with guidance counselors and assisting with Health Career Days, Health Career Clubs, and promoting health fairs. \$11,750 was made available for loans and scholarships to nursing and medical technology students.

We continue to support the concept of International Health Activities—local auxiliaries choose their own option—drug collection, making bandages, Johnny coats, and a new idea called SKIP—Scholarships for Kids of International Physicians. This, very simply, is a program of providing financial assistance to place children of physicians in underdeveloped countries in boarding schools while the physician father is providing medical care in the more remote areas of his country.

Our state newspaper, *Hoosier Doctor's Wife*, is published four times yearly and is a publication that Indiana can be proud of. Our editor, Jean Green, is also a contributing editor for the national publication, *MD's Wife*, and is a member of its advisory board.

The Community Service Committee was mainly concerned with setting up the visitation program by auxiliary members in the nursing homes of Indiana. A pilot program was started in Marion County in February, following a day-long orientation seminar presented by the State Board of Health. This program has been well received. Now several more counties are ready to activate their visiting program as soon as they have their orientation.

In January of this year, Dr. Norman Booher, chairman of your Commission on Voluntary Health Agencies, asked that the auxiliary form a comparable liaison committee to work with the state voluntary health agencies, as your Commission does. The Auxiliary Volunteer Health Services Chairman has been successful in forming such a committee, with one woman from each of your 13 medical districts, plus 2 members-at-large. A woman has been assigned to each of the health agencies and will attend its board meetings. Indiana is the first state auxiliary in the nation to form this type of liaison committee.

Legislation has been stressed as the AMA's number one priority this year. The auxiliary has tried to stress the importance of being legislatively informed—to make our members knowledgeable on Medigap and other national health insurance proposals. We have made a special effort to be certain every MD and his family in the state of Indiana is registered to vote.

For the second consecutive year, In-

diana won the American Political Action Committee award for the state with the largest number of women members.

The auxiliary presented a total of \$21,151.21 in the AMA-ERF. This represents the largest amount ever given by the WA-ISMA and figures out to about \$8.38 per capita. However, this was not enough to win recognition for Indiana at the national WA-AMA convention. Awards are given in many categories, but each state that gives at least \$10 per capita is recognized. In 27 states, all money given to AMA-ERF, including that given by the physicians, is credited to the auxiliary of that state. Had this been done in Indiana this last year, the per capita giving would have been \$18.62.

The lovely kitchen area in the ISMA building was completed in April under the guidance of our immediate past president, Mrs. Stanley Chernish, at no cost to the medical association, with all plans approved by the state and Marion County health departments. Sixty place settings of dishes and flatware as well as other necessary utensils were purchased and a special commercial grill was installed to facilitate the preparation of meats. The total cost of the kitchen was \$5,650.

I was recently invited to attend an Alcohol Countermeasures Forum for Women Highway Safety Leaders at Michigan State University. This forum presented a possible plan of action to try to reduce highway traffic fatalities and parallels, to a great extent, emphasis placed on a women's crusade for safety on the streets by the national auxiliary. I foresee some increased activity among auxiliary members in this direction under the guidance of our Health Education chairman.

A state workshop was held in May in Indianapolis, under the direction of our three area vice-presidents. The state officers and chairmen presented the program and ideals of the auxiliary to county representatives attending the conference. We were also honored to have as our guest speaker, Mrs. Howard Liljestrand of Honolulu, who is first vice-president of the WA-AMA.

This report is a summary of the many endeavors of the auxiliary. Whenever there is a service to be done for the community, our members are always ready to help. Service is an affair of the heart and an act of conscience. We are all proud to be a member of that very special sorority — physicians' wives. Thank you!



**Report of the Indiana Chapter,  
Student American Medical  
Association (Report given by  
Mr. Robert Barnes, secretary,  
Indiana Chapter)**

**HOUSE ACTION: Ordered filed.**

The SAMA Chapter of Indiana University School of Medicine now represents approximately 400 students in all four years of study.

Whereas, in the past our organization has confined its endeavors only towards its members, our Indiana Chapter and SAMA nationally have begun to work for the benefit of the entire health student community and for the population at large. Indiana Chapter officers for the academic year 1972-1973 are the following: Ronald Kracke, president; Dennis Pippenger, vice-president; Breck Lebeque, treasurer, and Robert Barnes, secretary.

SAMA programs nationally include at least 94 medical schools and our chapter at Indiana University takes part in many of these programs as well as some programs initiated locally. This year our chapter will sponsor several group discussions for students at the I.U. Medical Center in various disciplines on such topics as the population boom and its impact on the health fields, trauma treatment, death and dying, and women in medicine. The SAMA films and SAMA video journal on Station WAT 21 are available to students at the I.U. Medical Center as well as to physicians in hospitals throughout the state. Members of Student American Medical Association receive *The New Physician*, a monthly journal.

SAMA is responsible for giving first and second year medical students intimate exposure to clinical work through various summer work programs. MECO (standing for Medical Education and Community Orientation) places students in rotating work at hospitals in various small communities in Indiana. Participants earn from approximately \$70 to \$90 per week in addition to room and board. The objectives of this program are to give students in the basic sciences some reinforcement in their studies by making observations on patients and assisting in their total care. These students also see physicians in practice outside of the large metropolitan area to which their academic work might otherwise be confined. MECO presently has been instituted in 14 Indiana hospitals with a total of approximately 30 student participants each summer. We are in-

terested in expanding the number of hospitals and medical students involved and we appeal to the Indiana State Medical Association for assistance in this goal.

Nationally, SAMA sponsors programs for pre-clinical students in Appalachia, in the western United States with American Indians, and in migrant worker camps throughout the country.

We, as SAMA representatives and as students of Indiana University, invite your inquiries and participation in furthering and refining our present activities and initiating new ones so that our medical education be as comprehensive and relevant to current practice as possible.

**Report of Chairman of Blue  
Shield Board of Directors**

President Petrich, President-Elect Gosman, Members of the House of Delegates, distinguished guests, fellow physicians and friends: It is indeed a privilege and a pleasure and with a certain amount of pride that I present our annual report for you which is enclosed in your packet. I also wish at this time to publicly thank the members of the Board of Directors for their contributions during the past year on your behalf. I also wish to invite the members of the House of Delegates to breakfast at the Blue Cross-Blue Shield Service Center tomorrow morning starting at 7:30 and the breakfast line will close at 8:30, so I will be happy to have all of you there tomorrow morning for breakfast with Blue Shield in the Blue Cross-Blue Shield Service Center. At that time, after breakfast, we will arrange for any of you who desire for a brief tour of the building prior to the formal meeting in the morning. Wednesday we will have tours arranged, starting at 10:00 in the morning, 1:30 and 3:30 in the afternoon, for anyone who is interested in seeing your Blue-Cross-Blue Shield Service Center.

**Resolution in Tribute to  
Dr. William Harry Howard**

Doctor Santare asked that the rules be suspended to pass a memorial resolution in tribute to Dr. William Harry Howard, past president of Indiana State Medical Association. Resolution accepted by consent.

WHEREAS, Almighty God has called from our midst our brother and colleague, William Harry Howard; and

WHEREAS, Doctor Howard was a

past president of this association and served the medical profession and his patients faithfully for many years; and

WHEREAS, he has two sons who are physicians and members of this association; and

WHEREAS, he will be sorely missed by his colleagues, friends, patients and family;

NOW, THEREFORE, BE IT RESOLVED, that this Association extend its deepest sympathy and condolences to his wife and family.

**Greetings from Ronald Reagan,  
Governor, State of California**

It is my pleasure to extend greetings and good wishes to everyone attending this annual meeting of the Indiana State Medical Association.

Despite necessary and, I believe, appropriate government involvement in the purchase of health care services, it is to the medical profession that we must look for leadership in ensuring a balance between the public and private sector. In making health services available to all who truly need them, it is imperative that patients have the right to choose their doctors and that the doctor retains his right to treat patients in accordance with his professional judgment.

Hopefully, our mutual interest in the health and well-being of our citizens will direct us toward a responsible course of action which will remove the threat of excessive government intrusion into your world and result in the greatest benefit to the people, whose best interests must be our first concern.

Best wishes for an enjoyable and productive meeting.

**Reports of  
Officers**

**HOUSE ACTION: Ordered filed.**

**Executive Secretary**

The following is the report of the actions of the 1971 House of Delegates regarding resolutions and the disposition of those actions.

**RESOLUTIONS: 71-2. Restrictive Covenants.** Introduced at the AMA Clinical Meeting on November 1971 and was referred to the Judicial Council and reported back to the AMA House during the 1972 annual meeting. The matter was again referred back to the Judicial Council for further study.



71-3. *Declaration of Non-Participation Policy.* This was referred to the Board of Trustees and was reported to the House in Report A of the Board at this session.

71-4. *Medical Department, Board of Corrections.* This was again introduced in the 1972 Legislature and again was not passed into law.

71-5 and 71-17. *Both Dealing with a Moratorium on Amphetamine Drugs.* We have no knowledge of the number of physicians who have followed this recommendation.

71-7. *Invasion of Patient Privacy.* This was referred to the Board of Health and the Commission on Legislation. The form was changed by the Board of Health so that legislation was not necessary.

71-8. *Newborn Insurance Coverage.* A copy of this resolution was transmitted to the State Insurance Commissioner.

71-11. *Report of Annual Meeting.* Referred to the Budget Committee and the Board of Trustees. Allocation of funds was increased by these groups for the 1972 meeting.

71-12. *AMA Coding and Nomenclature System.* While adopted by the House, Blue Shield has taken no action to change to this system. We understand that it is a matter of economics as far as the Blues are concerned.

71-13. *Qualified Trainers in Sports Activities.* This resolution was forwarded to the State Superintendent of Public Instruction and to the Indiana High School Athletic Association.

71-14. *Continuing Medical Education.* Referred to the Commission on Medical Education and Licensure. Plan is being submitted to the House in the report of the Commission.

71-15. *Statewide Continuing Medical Education.* This resolution was also referred to the Commission on Medical Education and Licensure and they are reporting back to the House in their report at this session.

71-16. *Redefining Medical Districts.* Appropriate changes in the Bylaws have been made to conform to the action of House in the 1971 session.

71-18. *Federal Legislation By-Passing Local Health Departments.* This was referred to the Commission on Legislation.

71-19. *Parameters for Medicare and Medicaid Services.* Copies of this resolution were forwarded to HEW and the Indiana Congressional delegation.

71-23. *Recent Third Party Activities Concerning Graduate Medical Educa-*

*tion.* Referred to the Commission on Medical Education and Licensure.

71-24. *Flow of Illicit Drugs From Communist China.* Referred to the Board of Trustees for further study and, on investigation, it was the recommendation of the Board that this resolution not be adopted.

71-25. *Health Manpower.* Introduced by the Indiana delegation before the AMA 1971 Clinical meeting. It was referred to the Board of Trustees and reported back to the House at the 1972 annual meeting. The recommendation of the Board that the resolution not be adopted was sustained by the House of Delegates.

MEMBERSHIP:

Membership continues to show a slow but steady growth and I present herewith a comparison of membership of the last 10 years of the association, showing the gain and loss by years. Also in the figures below is the number of members that Indiana has in the American Medical Association. The final column in the report shows the number of Indiana State Medical Association members who have not seen fit to belong to the American Medical Association. While the membership in the association has shown a steady but slow growth, our membership has not grown as rapidly as some of the other states. Indiana seems to remain a state for producing physicians for other states and, according to the Dean of the Medical School, we do have more interns and residents in Indiana this year than we have had for a number of years. Hopefully this will reflect itself in additional manpower practicing medicine in Indiana and eventually becoming members of the Indiana State Medical Association.

The increasing number of physicians who are not members of the American

Medical Association should be of some concern to this House. You will notice that the drop off in the last three years has been rather rapid. Indiana is getting close to the mark of losing one of its delegates to the American Medical Association as the delegate apportionment is on the basis of one delegate for each 1,000 members or fraction thereof. While most of these non-members may have an honest difference of opinion with the AMA policy, nevertheless if there was ever a time when organized medicine should be bound together with a unified voice to combat some of the things which are facing the organization today, this is the time. It is hoped that, upon investigation by these members, they might reconsider their action and rejoin the American Medical Association and add strength to our forces at all levels of government.

We have, for years, had the State Board of Medical Registration and Examination commenting upon the number of physicians in Indiana. We have seen the American Medical Association reports indicate a different number of physicians in Indiana, as compared to our records.

In view of this, we obtained a listing from the State Medical Board, a listing from the American Medical Association, and we are checking these county by county. We find that many of these physicians who are listed in cities in the state of Indiana are not known or have not been heard of by the county medical societies. This study is also pointing out that apparently there has not been much effort made in those counties having interns and residents to bring them into membership in their county society. It would be fine if these counties would encourage interns and residents to join their societies and the Indiana State Medical Association and the American

ANALYSIS OF MEMBERSHIP TREND OVER PAST 10 YEARS

Year	ISMA	Gain	AMA	Gain	ISMA Members Non-AMA Members
	7/31	Loss	7/31	Loss	
1961	4298		4178		120
1962	4307	+ 9	4184	+ 6	123
1963	4330	+ 23	4222	+ 38	108
1964	4331	+ 1	4225	+ 3	106
1965	4356	+ 25	4255	+ 30	101
1966	4367	— 11	4254	— 1	113
1967	4356	— 11	4180	— 26	176
1968	4400	+ 44	4246	+ 66	154
1969	4450	+ 50	4301	+ 55	149
1970	4457	+ 7	4291	— 10	166
1971	4489	+ 32	4236	— 55	253
1972	4526	+ 37	4179	— 57	347



Medical Association to encourage these new doctors to work with organized medicine in resolving the problems of the profession. There also seems not to be much activity in bringing osteopaths into membership in county medical societies since the House of Delegates changed the rules to permit osteopaths to become members of the State Medical Association and the American Medical Association. This would also be a source of membership if osteopaths throughout the state are deemed to be eligible for membership by the respective county medical societies.

The field staff of the association stands ready at any time to be of assistance to county societies in calling upon or encouraging eligible individuals to place their application for membership in their respective societies.

#### CHAMPUS:

The administration of the CHAMPUS program by your Association continues to draw plaudits from the Army for the method by which we have been handling it. The national goal for claims backlog is 10 working days. Indiana has been running between 3 and 5.4 days, which is well below the national average. During the year beginning August 1, 1971, and ending July 31, 1972, the Association processed 17,510 claims amounting to \$1,453,131.16. While the activity in this department has increased year by year, as a result of visitation by one of the officers from Denver in July, indications were that the department will be further expanded before the coming year ends.

#### FIELD SERVICE:

The field service has been actively engaged this past year in checking out the number of doctors in each county in the state of Indiana, as well as again visiting the members of the state legislature and serving as lobbyists during the legislature. Legislation activities are taking more and more of the fieldmen's time and keeping them, therefore, out of their districts which, we hope, will soon be put to an end by the employment of a person to handle most of this work.

#### LEGISLATION:

Your secretary believes that it might be worthwhile to repeat portions of the report he made to the Board of Trustees at their meeting on January 9, 1972. This is not necessarily to be repetitious but I feel that the members of the House

of Delegates should be aware of some of these matters.

Up until the year 1972 we had a session of the legislature lasting 60 working days in odd-numbered years. The voters approved a constitutional amendment so as to hold an annual session of 30 working days in the even-numbered years in addition to the sixty working days in odd-numbered years.

1972 marked the beginning of the 30 day sessions. Some of you may not know how the state legislature operates. In the past it was customary for organizations or individuals to write a bill and then solicit some member of the legislature to introduce the bill. You would then hand this bill to the member who would take it to the Legislative Bureau and have it checked for constitutionality and jacketed and numbered. When the legislature convened, each legislator was permitted to introduce "x" number of bills per day and these were referred to committees of the House or Senate who held public hearings on them and then reported them to the floor of the Senate or the House with recommendations that the bill do pass, do pass as amended, or they would kill the bill in committee by not reporting it out on the floor. There were many times when the bill as originally introduced was stripped entirely of its contents in committee and another bill inserted, which means that you had to be on constant alert to review all bills and constantly watch the action of the committees as well as the floor of the House and Senate to be sure that something was not slipped in that would be harmful to the medical profession.

Beginning with the '72 session, we are now in an entirely different ball game. The legislature of 1971 created a legislative council which is a rather all-powerful agency that rewrites all bills, numbers them, and sometimes even selects the member of the legislature who will introduce them, which means that we have a 12 month per year working force working on bills for the legislative session. In 1972 bills were numbered and referred to committees early in November of 1971, although the legislative session of the House did not begin until January 11, 1972. Bills introduced in November and December were already referred to various committees of the House and Senate and most of these committees held public hearings on these bills and took action as to their disposition even prior to the date of the beginning of the session on January 11th.

As of January 9, 1972, your secretary reviewed some 54 bills in the '72 ses-

sion that had something to do with health or the practice of medicine. I will predict at this time that the time is very short before we will have a full time professional, year around legislature in the state of Indiana. This activity then raises a question as to what your association is going to do regarding coverage of the state legislature.

Today legislative council committees are meeting weekly and we have been attempting to cover them by using the field staff. The Board of Trustees has finally given permission to the secretary to employ a person to operate in this particular field and handle these legislative matters. Hopefully, this can be accomplished before the first of the year.

With the trend toward a full time legislature, it means that physicians in respective county societies from where the men are elected should make a sincere effort to be in constant contact with these men and offer their advice and counsel on measures which appear before the legislature affecting the public health and the practice of medicine.

#### PUBLIC RELATIONS:

At the January meeting of the Board of Trustees I reported among a number of other items of vital concern to the Association the need for a public relations program.

I told the Board, and I quote from my own report, "This is an important and integral part of any association and while we have limped along with a meager P.R. Program, we have never really sat down and determined what we should do in the way of a full blown public relations program. As I point out in my report, some of the suggestions in this particular area, and I might add that plans for some of these are already on the drawing board, or I should say in the blue print stage, it is going to cost us approximately \$25,000 to launch such a program. I believe it is time that we decide to institute an organized P.R. campaign and discontinue our hit-and-miss attitude that we have had on this subject. Of course, this costs money too."

In developing the "blue print" for a public relations program the Association should consider that the continuing criticism of organized medicine by its members is that it is not "telling its story to the people." Consequently, such a program should be geared to accomplishing this. This program should include material which would emphasize throughout how ISMA activities benefit Hoosiers.



The various means of communication would be provided by the following:

1. Television Spots
2. Radio Spots
3. Newspaper Ads
4. Indiana Magazine Ads
5. Billboard Posters
6. Exhibits

Subjects which would be communicated through the above six areas and which would have appeal to the public would be:

1. Legislation
  - Development of Physicians' Assistants' Programs
  - Statements on National Health Insurance
  - ISMA support of public health measures
2. Rural Health
  - Measures being taken by ISMA to help find solutions to the doctor shortage
3. ISMA concern with the high cost health care and steps being taken to help solve the problem; i.e., utilization review, etc.
4. Activities in the drug education field and treatment of the addict.
  - Use of Hoosier Teen Health Happening tapes and films and distribution of drug literature.
5. ISMA concern with continuing medical education and programs now being developed for Indiana doctors.
6. Emergency medical services — ISMA activity in this area; i.e., upgrading ambulance services, improving emergency rooms in hospitals, proper use of the emergency room by patients, etc.
7. Preceptor program — emphasize the efforts of the ISMA to encourage young doctors to stay in Indiana to practice.
8. ISMA Convention activities with emphasis on resolutions, reports and actions of the House, which affect the Indiana public.
9. Cooperative projects with I. U., voluntary health agencies, Blue Shield, hospital association, etc.
10. ISMA policy and attitudes of physicians in the socio-economic area.
  - Doctor-Patient relationship
  - Relationships with health insurance carriers, governmental medical programs, etc.
  - Statistics on doctor-to-population ratios, comparisons of medical costs with health care costs and other costs, etc.
11. Communication of health tips on

current problems such as drug usage, alcoholism, heart disease, etc.

12. Explanations of the ethics of medicine.
  13. Grievance Committee activities and reasons for existence.
  14. Structure of ISMA, with emphasis on local physician involvement.
  15. Promotion of certain literature items available through ISMA and AMA. Keep supply on hand to meet requests.
  16. Medicine as a career as well as other medically related career opportunities.
  17. Quackery in medicine with emphasis on chiropractic.
  18. Standards for athlete physical exams being developed by Commission on Sports and Medicine.
  19. Increasing activity of physicians and clergy working together with patients.
  20. Student loan program of the ISMA.
  21. Future plans of organized medicine which relate to the public.
- Booklets which might be developed are:
1. Booklet on how to avoid malpractice suits already in final planning stages).
  2. Drug treatment booklet (now being planned by the Subcommittee on Drug Addiction and Alcoholism).
  3. Booklet on current problems in nursing homes (now being formulated by Commission on Aging).
  4. A code of cooperation for physicians, hospitals, TV, radio and press.
  5. A booklet on poisons and actions to be taken by individuals before seeing the doctor.

These are only a few suggestions which could be utilized in setting up a continuing program of public relations. The list can be added to endlessly as new ideas develop each year through the Board of Trustees and its committees and commissions.

In the past it has always been the Association's action to take steps in a public relations sense when a specific problem would arise. This is a "too late" procedure and meeting problem issues is only a minute part of public relations.

A continuing public relations effort would be similar to a continuing advertising program by a large corporation to sell the name of the company and specific products produced by the company.

In a similar sense, the Public Relations of the ISMA would function. It would be based on the good works of the Association and its members on a year round basis through the media mentioned earlier in this report. It could also meet the demands of current problems as they arise for the profession, and rather than be stamped as a negative and do-nothing group, the ISMA could develop for itself a new personality based on its continuing interest in and accomplishments for patients and public.

At the time of the writing of this report I am aware that the Commission on Public Information may be submitting a request for budget support for the proposal which I have outlined. I would urge the House of Delegates to give serious consideration to such a program.

#### USE OF BUILDING:

From January through the end of August, we have a record of the following meeting schedule, and this includes a seven-day week schedule since most committees meet on Saturday and/or Sunday.

- Meetings held in Headquarters Office .....71
- Included in the above figure are: ISMA Commissions and Committees .....56
- Included are other related medical groups and specialty societies and such groups as Directors of Medical Education and Indiana Regional Medical Program Board .....15

This includes 71 actual days of the 244 days during this series of months, over two months of time spent in Headquarters operation in an eight-month period, and out of 37 Sundays, the building was open 17 for meetings.

It can readily be seen that the meeting schedule is on the increase, with more and more medical and related groups taking advantage of the excellent meeting facility.

#### ISMA SERVICES TO OTHERS:

Your association headquarters remains a constant source of inquiry; requests for assistance and advice in the field of medical care and other health related areas. Each day brings requests from the public or government offices or others things daily carried on in your headquarters office which are separate from the projects and considerations of the commissions, committees, Board of Trustees, and special committees which



during the year work in different project areas, all of which are staffed and coordinated by the headquarters office.

1. Almost daily we have requests for information on the Indiana law pertaining to foreign physician licensure in Indiana to individuals, Universities in other states.

2. We have prospective medical students asking us for information concerning entering the medical school.

3. Provide the American Medical Association with information concerning the activities of our committees and commissions.

4. Provide the AMA News with material pertaining to the Indiana State Medical Association and newspaper clips on periodic basis.

5. Prepared orientation kits for use by the field staff in contacting new physicians locating in Indiana.

6. We continue to provide tapes and video tapes of the Hoosier Teen Health Happening to television stations and to the schools in the state of Indiana.

7. Assisted out-of-state physicians in acquiring information on Indiana licensure laws.

8. Provide kits and materials on drugs and drug abuse to students, teachers and physicians.

9. Provide materials to health teachers for development of health and safety files for teaching purposes.

10. Provide many materials on a variety of health subjects for research papers.

11. Assist county societies in procuring films and speakers for their meetings.

12. Assisted in promotion of district society meetings.

13. Provide news stories and background information to the news media on association activities and policies.

14. Provide information to members of the Indiana General Assembly on ISMA policies regarding bills which will have an effect upon the public health and the practice of medicine.

#### *SERVICES TO MEMBERS:*

While the association has instituted many new services to members, there are other areas which might be well worth exploring. With the computer age being here, it might be well for the association to give some thought to developing a computer system for handling the billing, accounting and tax services for members of this association. The rapid development in the capability of a computer system would make it easy for a

doctor to install a console in his office from which he could daily have his office girl transcribe to the computer his office calls for that day and the charges to be made. Such a system would be a very economical one if it was proved to be successful and feasible and a large portion of our members joined in the function of such a program. In any event, I would urge that the Association study this particular area of additional service to the membership of this association.

#### *WELFARE PROGRAMS:*

As though we don't have enough problems already existing in the various welfare programs and Federal programs for welfare recipients, we now have another one which is going to be forced upon us in June of 1973. New regulations have been issued to take effect at that time which provide that states must make possible for all youth under 21 years of age to receive health screening, diagnosis and therapeutic care under a new program at the expense of the government. It is estimated this will encompass approximately 200,000 more individuals in the state of Indiana and that a minimum conservative cost has been estimated by the budget department of costing the taxpayers of Indiana a minimum of \$50,000,000 per year.

Those of you who have been following the newspaper reports are well aware of the difficulties existing now between the welfare department and the state legislature. It is rather evident from reading the papers and sitting in the council meetings of the state legislature advisory committee that things are not well as far as controls of these programs are concerned.

Your Association has been approached about developing a plan either at state or regional level for the purpose of handling both utilization and peer review under the welfare program.

In discussing this with some of the welfare officials it appears that we may be reverting back to the old county review committee system which we had years ago and which apparently worked very well.

Several states have undertaken this responsibility, the latest being the state of Illinois, in which the state medical society is handling these programs and problems for their state government. Georgia, for example, the state medical association there handles all the programs of welfare, Medicare for not only physicians but hospitals as well. The dilemma, no doubt, is brought about by many involved who do not have

medical background or knowledge and do not know how to put the program together to make it work. Therefore, it appears that the government is beginning to look to medical organizations to try and pull them out of this dilemma. This, perhaps, is another area which we should probably dig into with a serious study as to what, if anything, medicine can do or is willing to do with respect to assisting and controlling this growing cancer.

#### *ANNUAL MEETING:*

I would like again to reiterate what I reported to the House in 1971 and to the Board of Trustees at their meeting in January of '72, that the time has come for us to give serious consideration to methods of financing our annual meetings. The activities of your association and of your annual meeting have been caught in the inflation spiral the same as everything else. At the same time, the demand for exhibit space is consistently falling.

Guest speakers are more expensive, transportation and housing for these people are more expensive and in order to give a well rounded program it necessitates bringing in more and more speakers for each annual meeting. The cost of your annual meeting is nearing the figure of \$30,000 per year and exhibit income is dropping a few thousand each year; so it means that either we discontinue the annual meeting, or we increase the dues to pick up the difference, or we charge registration fees, or we charge a fee for participating in the scientific programs. The Finance Committee of the Board of Trustees currently has had the matter under study and, I believe, will make a recommendation to the House concerning this problem. I would hope that you would support the Finance Committee in whatever decision they reach regarding your annual meeting. I think your meetings are going to continue to grow in importance and in character, as more and more of the specialty groups and the sections take on the responsibility for the scientific presentations made at our annual meeting.

It is hoped, too, that the Delegates from the various counties will go back home and encourage the members in their respective societies to actively participate in our annual meeting, because a large attendance also helps sell exhibit space and thereby cuts down the necessity of the Association picking up the deficit.



THE YEAR AHEAD:

As one looks ahead I am sure that there will be no decrease in the necessity of your Association being active in more and more fields than they have ever been in their history. We are seeing the development of more and more health programs. The push for the establishment of HMOs, the push for the establishment of group practice clinics in order to handle some of the welfare programs, and no doubt some attempt is to be made to delimit the number of visits a person may see their doctor and perhaps even the establishment of a Federal fee schedule and treatment method.

Continuing education is going to be an important adjunct to this Association during the coming year and I am sure that with some of the ideas expressed by the incoming officers and some of the commission people, we can anticipate a busier year than we have had in a decade as far as the activities of your Association is concerned.

Communications continues to be a problem in getting the message down to the individual doctor as to what his organization is doing in his behalf. We are hopeful that more societies will invite ISMA officers to visit with them at least once a year to discuss some of the activities of the Association and some of the things that organized medicine is attempting to do in the interest of the individual member.

As I mentioned before, computer technology—not only in the practice of medicine but in the business aspect of the physician—will show great advancement during the coming year. Supplying health manpower to satisfy the needs of this state is a problem we will face in the coming year. The role of third parties must be closely watched during the coming year. As previously pointed out, legislative activities are going to be speeded up tremendously during the coming year.

The Indiana State Medical Association cannot afford at this time in history to turn over to other organizations its own responsibilities in any one of the suggested problem areas I have outlined. Neither can we remain static. We will regress or we will progress.

In the 123 years of the organization of the Indiana State Medical Association, we have an enviable history of progress in resolving any problem that threatened the health of the public of our state. The activities of your organization at the present time, the leadership which you are providing, the interest that more members are showing in the commissions and committees and their activities, should be assuring to all that, regardless of what the situation is, Indiana physicians will lead in resolving and bringing solutions to any area in which we might be confronted.

Your staff is ready and willing at all times to carry out to the best of our

ability any program devised for the furtherance of this association, the welfare of the physician and the protection of the public health.

JAMES A. WAGGENER,  
*Executive Secretary*

The Treasurer

HOUSE ACTION: Ordered Filed.

Listed below are the fund balances as of July 31, 1972, in lieu of the audit which will not be available until after the close of our fiscal year September 30, 1972.

During the past year we have combined *The Journal* funds and the petty cash funds into the general fund for better accounting and control.

We have endeavored to utilize short term treasury bills for investing every possible cent of funds not immediately needed in order to earn as much interest as possible. We have exchanged our old 2.5% bonds maturing December 31, 1972, for 1976 bonds earning 5 7/8%.

Our bookkeeper, Mrs. Reilly, has provided the Budget Committee, Executive Committee and the Board with the most complete review of our business affairs in our entire history. These reports are carefully reviewed by the respective committees and Boards and their advice is followed by your Treasurer.

Lester H. Hoyt, M.D.  
*Treasurer*

INDIANA STATE MEDICAL ASSOCIATION  
Statement of Financial Condition at July 31, 1972

ASSETS	General & Journal	Building Fund	Medical Fund	Student Loan	TOTAL ALL FUNDS
Cash in banks—operating .....	56,864.38	3,821.40	1,287.85	—	61,973.63
Cash in banks—interest bearing .....	20,000.00	6,519.97	15,675.26	19,775.37	61,970.60
Short term treasury bills .....	205,019.47	93,259.97	—	—	298,279.44
Accounts receivable .....	9,565.21	384.35	127.71	65.92	10,143.19
Prepaid expenses .....	12,846.10	727.24	—	—	13,573.34
Long term investments .....	84,404.84	—	25,095.13	20,810.00	130,309.97
Property—less reserve for depreciation .....	12,430.47	414,130.89	—	—	426,561.36
Total Assets .....	401,130.47	518,843.82	42,185.95	40,651.29	1,002,811.53
LIABILITIES AND FUND BALANCES					
Accounts payable .....	8,815.29	1,205.00	—	651.29	10,671.58
Property taxes accrued .....	—	2,167.93	—	—	2,167.93
Deferred annual meeting .....	9,425.00	—	—	—	9,425.00
Dues payable to AMERF .....	19,915.00	—	—	—	19,915.00
Non-interest bearing notes .....	—	21,325.00	—	—	21,325.00
Advances from AMA .....	10,033.71	—	—	—	10,033.71
Deferred dues income .....	156,520.00	—	—	—	156,520.00
Total Liabilities .....	204,709.00	24,697.93	—	651.29	230,058.22
Fund Balances October 1, 1971 .....	190,909.78	470,496.93	36,747.98	40,000.00	738,154.69
Profit 10 months .....	5,511.69	23,648.96	5,437.97	—	34,598.62
Fund balances at 7/31/72 .....	196,421.47	494,145.89	42,185.95	40,000.00	772,753.31
Total Liabilities and Fund Balances .....	401,130.47	518,843.82	42,185.95	40,651.29	1,002,811.53



## Chairman of the Board

### HIGHLIGHTS OF BOARD OF TRUSTEE ACTIVITIES 1971-1972

#### HOUSE ACTION: Ordered filed.

1. Approved the American Cancer Society's program of installing a system of telephone dialing for educational information on cancer. The system is established for utilization by Indiana physicians.
2. The Board approved the Association's endorsement and advertisement of group travel plans for the members and inaugurated the program with a trip appropriately named a "Scandinavian Adventure."
3. Approved informing the membership of a legal ruling that physicians' medical records are no longer confidential in suits by patients, and must be made available to the plaintiff and the plaintiff's attorney. The action of the Board was the result of a suit by a welfare patient against the State Department of Public Welfare for denying disability payments.
4. Recommended and approved that questionnaires circulated to physicians wishing to participate in the preceptor program be approved by the president of the county medical society and remain in the confidential files of the ISMA, with only a yes-or-no comment relayed to Indiana University for their files.
5. Approved of the president's naming a committee to work in conjunction with a Museum for Indiana Medical History, with the objective of collecting historical and significant items of Indiana's medical history and maintaining them for exposure to physicians and students. Site of the museum is the old Pathological Building on the grounds of Central State Hospital, Indianapolis. The Board later approved to recommend to Directors of the Medical Education Foundation that \$10,000 be granted.
6. Installation of kitchen in the basement of the Headquarters Building was accomplished with the approval and direction of the Board.
7. Now in progress is the publication by the ISMA of a booklet entitled, "Physician's Liability in Patient Care" as the result of Board action upon the suggestion of the Commission on Public Information.
8. Referred to the Future Planning Committee of the Association the

possibility of expansion of the Headquarters offices and the need for increasing staff. Also referred matters on building expansion to the Building and to the Finance Committees.

9. The Board increased the budget for the Convention Arrangements Commission to cover expenses of speakers.
10. Proposed merger of Blue Shield and Blue Cross staffs was discussed at length by the Board. Board directed that the trustee in each district communicate with his Blue Shield Board member personally, urging him to not promote any form of merger or combination until more information was available.
11. Approved transferring the printing of the ISMA *Journal* to another company in the interest of more satisfactory service.
12. Supported a motion that the Medical Review Committee of the ISMA, in keeping with the policy established by the House of Delegates in 1969, function only at the request of and assistance to County Medical Review Committees.
13. Approved increases in the Blue Shield-Blue Cross professional health security plan for members of ISMA.
14. Board took action to ascertain from the legal counsel of ISMA how physicians could be protected from law suits arising from the usual and customary fee concept. Board also planned an investigation of the Motors contract and Resolution 26 and how it applies to individuals rather than to the society.
15. Funding for continuing medical education programs for physicians, externs, interns and medical residents, under the Indiana Plan for Medical Education to receive support by ISMA through appropriate legislation. Board approved joining with Indiana Hospital Association, the Indiana University School of Medicine and Directors of Medical Education in promoting legislation for funding.
16. At the time of this report the Board had been approached with a proposal to jointly field staff the Regional Medical Program with the ISMA Field Service. The Board tabled the proposal until more details on such a combined effort would be forthcoming.
17. Board approved the purchase of 20,000 copies of a booklet on "Medicare Misconceptions" for distribution to ISMA members. The booklet explains in simple, direct language to

patients what Medicare does not cover.

18. Concerning the National Health Service Corps and the assignment of Public Health Service physicians to physician shortage areas in Indiana, the Board moved that those areas requesting certification of the need in an area from the Indiana State Medical Association be investigated by the ISMA District Trustee, through the County Medical Society, and a report made to the Board at the next meeting following the request for approval.
19. In line with this action, the Board also advised the Headquarters Office of the Association to send a digest of the law in the Newsflash to all county societies so they will be informed in advance of any such plan for their communities.
20. A letter to the Headquarters Office of the ISMA from the Joint Commission on Accreditation asking for information on medical staff problems in six Indiana hospitals was reviewed by the Board. After much discussion the Board delayed action, contingent upon reports from trustees as to the specific situations, hospital by hospital, referred to in the letter.
21. Board approved the development by the Headquarters staff of a brochure or fact sheet detailing information regarding Medicaid and Medicare, for distribution to the membership.
22. A plan for reorganization of local health departments in Indiana was submitted to the Board by the Commission on Public Health. The Board accepted the report and appointed a committee of the Board to develop a plan for action.
23. Board discussed the National Communicable Disease Center's statement presented by the State Health Commissioner concerning "health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination." Dr. Andrew C. Offutt, State Health Commissioner, presented his statement to the Board which said, in essence, that "immunization remains a medical decision." The statement further said, "It is submitted that to change the policy in Indiana, where we have never felt the need for a compulsory immunization statute, is unnecessary and should remain a medical judgmental activity, and that smallpox vaccination be continued as in the past." The Board adopted the statement.
24. Board approved Public Informa-



tion Commission's proposed placard on questions and answers in the medical, socio-economic fields. The placards would be utilized in physicians' offices for patient education.

25. Board approved the distribution of a booklet to all members through the *ISMA Journal* on "Treatment of Acute Drug Intoxication."

26. Resolution 71-3, Declaration of Non-Participation Policy, was reviewed by the Board and referred back to the House of Delegates with amendments.

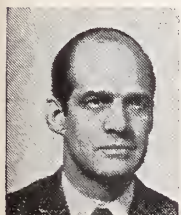
In addition to these specific actions, the Board of Trustees at each meeting received in-depth reports from the Indiana University School of Medicine, the Indiana State Board of Health, Blue Shield, Department of Welfare and other groups.

The Board also plans and participates annually in such programs as the Washington legislation's visitation program, student-faculty-ISMA member meetings and a number of other activities which are not listed in this report.

JOE DUKES, M.D.,  
Chairman

## First Trustee District

**HOUSE ACTION: Ordered Filed.**



GILBERT M. WILHELMUS,  
M.D.,  
Trustee

The annual meeting of the First District Medical Society was held on April 13, 1972, at the Petroleum Club in Evansville. The meeting was well attended with over 160 members and their wives (in fact, reservations had to be curtailed because the Club could not serve a larger group). Mead Johnson Company was host for our social hour preceding the dinner.

Dr. Joseph C. Robert of Richmond, Va., who holds many honorary degrees from Furman University, Washington Lee University, Medical College of Virginia, etc., was our speaker. This noted lecturer, author, and educator spoke on the subject of "The Healing Arts In The American Way." Dr. Peter Petrich, ISMA president, and Dr. James Gosman, ISMA president-elect, were present and gave an excellent and comprehensive re-

port on our business at the state and national level. Dr. Gilbert Wilhelmus, trustee, gave a report in regard to the AMA's Socio-Economic meeting held in Ft. Lauderdale, Fla., and a more detailed report in regard to state medical business related to the First District. Dr. Willard Barnhart, First District representative on the Blue Shield Board of Directors, and Mr. Herbert Dixon, vice president of professional relations, gave a report on the activities of Blue Shield.

After the meeting the following officers were elected:

Bernard Rosenblatt, M.D., president  
William Dye, M.D., vice president  
John Winebrenner, M.D., secretary-treasurer

As in the past, postgraduate medical education is one of our primary interests in the First District. The number of interns and residents is increasing yearly. Frequent symposiums and lectures given by the Indiana University Medical School faculty are well attended. Many of our physicians are extending their postgraduate education to such far away places as the Scandinavian countries, Africa, and the Far East.

As in the past, now, and probably will be in the future, government involvement in medicine was discussed at our medical society meetings. With Phase II starting the past year, this has been thoroughly researched and the members have been informed of the "do's and don't's" of this program.

One of the values of the experience of being a member of the Board of Trustees of the Indiana State Medical Association is the opportunity of seeing how organized medicine is attempting to help each and every one of the physicians in the organization. It is obvious that whether a person is a specialist or a general practitioner, practicing in a large or a small community, the problems are very similar.

The Trustee wants to thank the many members of the District for their cooperation and activity in their local medical society and participating on the Commissions and Committees of the ISMA. The District appreciates the efforts of Mr. Robert Amick for his attendance and suggestions throughout the entire district.

The Trustee is grateful for the cooperation and the opportunity to serve his fellow physicians in the First District.

GILBERT M. WILHELMUS, M.D.  
Trustee

## Second Trustee District

**HOUSE ACTION: Ordered filed.**



JOSEPH E. DUKES,  
M.D.,

Trustee

The Second District annual meeting was held Thursday afternoon May 18, 1972, at the Officers Club of Crane Naval Depot. Greene County Medical Society was the host with Robert E. Moses, M.D., presiding, and J. S. Brown, M.D., as secretary. There was a good representation from each county.

The meeting featured Ray W. Gifford Jr. M.D., head of the Department of Hypertension and Renal Diseases, Cleveland (Clinic Foundation) Cleveland, Ohio. His subject was "Management of Hypertension—Is It Really Worth While Treating?" A question-and-answer period followed his talk.

The Crane Medical Department then presented a film about the Crane Naval Depot. This was a very informative film concerning the activities and works of the depot.

A business meeting was then held prior to the dinner hour, at this time a new trustee for the Second district was elected, Dr. Paul W. Holtzman of Bloomington. Owen-Monroe County extended an invitation to be hosts for the Second district meeting next year.

JOSEPH E. DUKES, M.D.,  
Trustee

## Third Trustee District

**HOUSE ACTION: Ordered filed.**



ELI GOODMAN, M.D.

Trustee

The 1972 meeting of the Third District was held at New Albany in the Robert E. Lee Inn. Presiding was Dr. Daniel Cannon.

This meeting was held simultaneously with the annual meeting of the Third District Academy of Family Physicians.

The trustee gave a report of activities of the Board of Trustees of the Indiana State Medical Association and made a special plea for solidarity and support of both the Indiana State Medical As-



sociation and American Medical Association.

An excellent afternoon and after-dinner program about problem oriented history taking was presented.

After some discussion about the continuity of District and State meetings, it was voted to change the annual District Meeting date from May to September.

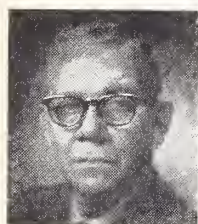
Dr. Claude E. Meyer was elected president and Dr. Robert McKechnie was elected secretary-treasurer of the District.

The 1973 annual meeting of the District will be held in September at the Marriott Inn in Clarksville.

ELI GOODMAN, M.D., *Trustee*

## Fourth Trustee District

**HOUSE ACTION: Ordered Filed.**



JACK E. SHIELDS,  
M.D.,  
*Trustee*

The District meeting of the Fourth District was held in Madison at the country club on May 17th. The evening dinner was well attended. Our main speaker was a celebrity of the news media from Channel 3 in Louisville and gave a rather humorous presentation.

Members of the District were particularly pleased that the ISMA president and president-elect attended the meeting. Jim Waggener, executive secretary, was also present. This, also, the District appreciated.

A golf game was held in the morning with co-winners: Dr. Leslie Baker of Aurora, Dr. Bob Zink of Madison.

Elections were held by the delegates from the different counties. Dr. Shields, who accepted the office of trustee from the Fourth District a year ago and at that time stated he would hold the office for a year and would in the meantime hunt for a qualified young physician to take his place. Dr. Howard Jackson of Madison was nominated and then elected trustee without opposition, and he was elevated from his position of alternate trustee. A young physician from Seymour, Dr. William Blaisdell, highly qualified for this position, was nominated and elected without opposition to the position of alternate trustee. This, in fact, makes District Four with the youngest trustee and alternate trustee of any of the districts in Indiana. Of course Dr. Shields resigned as he stated he would.

Dr. Black, who is at present on the Blue Shield Board and has been for many years, was nominated to succeed himself in this position. In opposition, Dr. Alvin Henry, ophthalmologist from Columbus, was nominated. With a very close vote, Dr. Henry was elected and he will represent the Fourth District in the future on the Blue Shield Board.

The other so-called routine elections were for president and president-elect, secretary and treasurer of this District Society for the ensuing year. Dr. Kenneth Schneider from Columbus was elected president and the next year's meeting will be held at Columbus. Dr. C. David Ryan, Columbus, was elected secretary and treasurer. Dr. Shields was elected president-elect.

There are approximately 35 doctors in Bartholomew County, the county in which next year's meeting will be held, and we are looking forward to a big meeting, well-attended, next May. That date has not been chosen.

JACK E. SHIELDS, M.D.,  
*Trustee*

## Fifth Trustee District

**HOUSE ACTION: Ordered filed.**



WILBERT McINTOSH,  
M.D.,  
*Trustee*

The Fifth District Meeting was held on May 24, 1972, at the Terre Haute Country Club.

The meeting was called to order at 3:00 p.m., by the president. A panel consisting of Doctors Guy A. Owsley, Raymond H. Murray, and Patrick Corcoran discussed utilization review, HMOs and foundations. This was a very informative discussion. Many questions were asked from the group.

Other visitors included Mr. Herb Dixon of Blue Shield, who discussed the up-coming annual meeting in October. Also present was Mr. James Waggener, executive secretary, and Mr. Robert Amick, field secretary. Mr. Amick made a brief report.

Doctor James H. Gosman, president-elect was also present. After discussions by visiting dignitaries, an election was held. Dr. Cleon Schauwecker was chosen Trustee to replace Doctor McIntosh. Doctor William G. Bannon was elected alternate trustee to succeed Doctor

Schauwecker.

The business meeting was adjourned at 5:00 p.m. A dinner was held at 7:00 after a cocktail hour. Dr. Otis Bowen was the principal speaker.

WILBERT McINTOSH, M.D.,  
*Trustee*

## Sixth Trustee District

**HOUSE ACTION: Ordered filed.**



PAUL M. INLOW,  
M.D.,  
*Trustee*

It is my pleasure to announce that Dr. Glen Ward Lee of Richmond is the new alternate trustee from this district.

This district congratulates a member, Fayette County, the home of the 1972 State Basketball Champions.

Mr. Phillip Willkie of Rushville has continued to speak for legislative change to lift restrictions for licensure of foreign physicians who wish to practice in Indiana. He sees this as a solution to easing the physician shortage in small communities.

The Sixth District Meeting was held in Shelbyville on May 3, 1972, at the Holiday Inn. There were 45 members present, with President Mark Smith presiding. Dr. Guy Owsley, Dr. D. Edmund Storey and Dr. Raymond H. Murray explained Peer Review, Medical Foundations and HMO's. Pertinent and lively discussion followed. Dr. and Mrs. Peter Petrich and Dr. and Mrs. James Gosman, president and president-elect of the Indiana State Medical Association, were welcome guests.

New officers are: President, John Moenning, M.D., Greenfield; Vice-President, James H. Tower, M.D., Shelbyville; and Secretary-Treasurer, Davis W. Ellis, M.D., Rushville. District dues were increased from \$1.00 to \$2.00. Rush County will be host to the 1973 meeting.

Dr. Walter Judd, long-time Minnesota Congressman, was the dinner speaker. He spoke on China, world communism and the world political situation. He challenged his fellow physicians to become involved in politics so that they might have more control over the drafting of legislation affecting the practice of medicine. I believe more physician involvement in the Indiana State Medical Association would be a good place to start.

P. M. INLOW, M.D., *Trustee*



## Seventh Trustee District

**HOUSE ACTION:** Ordered filed.



**DWIGHT W. SCHUSTER, M.D.,**  
Trustee

The Seventh District held its annual meeting on June 14, 1972, at the El Dorado Country Club, Greenwood. Dr. John Records of Franklin, as President, presided at the business meeting. In spite of heavy rain and a thunderstorm, a good number of golfers braved the El Dorado course. At the business meeting it was moved and accepted that the *District dues be increased from twenty-five cents to \$1.25 a year, in order to expand the Seventh District's activity and to make it more meaningful for its members. A \$2.00 per member assessment for 1973 only was also agreed upon.* The use of the \$2.00 assessment is to provide funds for the Seventh District to hold a reception in honor of Dr. James Gosman at the October 1972 Annual ISMA meeting. Dr. Gosman will be elevated to president of ISMA at that meeting.

The following were elected to office: Dr. Joseph Ferrara of Franklin was elected to succeed Dr. Dwight Schuster as trustee. Dr. John Pantzer of Indianapolis was elected alternate trustee to succeed Dr. Ferrara, and Dr. Don McCallum of Indianapolis was elected alternate trustee to succeed Dr. Joseph Kerlin of Danville. Dr. Stafford Pile of Indianapolis was elected to represent the Seventh District on the Blue Shield Board of Directors to succeed Dr. Glen Ryan. Dr. Eric Clark of Plainfield was selected as president elect of the 7th Trustee District. Dr. Malcolm O. Scamahorn of Pittsboro was elected Secretary-treasurer.

After dinner, Dr. Records introduced the speaker of the evening, Dr. Otis Bowen. Dr. Bowen gave an excellent address and fielded questions afterwards in a very effective fashion. At the conclusion of the meeting, Dr. Records turned the gavel over to the incoming president, Dr. Donald Stephens of Indianapolis. Dr. Stephens congratulated Johnson County for a good meeting and prophesied that the Seventh District was going to continue to grow in activity and stature. He announced the next meeting would most likely be held at the Speedway Motel in mid-June 1973.

As the retiring trustee of the Seventh District, I wish to thank all who have

helped me during my tenure on the ISMA Board and to ask your continued support in my efforts as chairman of the Physicians Committee to Re-elect the President in November 1972.

**DWIGHT W. SCHUSTER, M.D.,**  
Trustee

## Seventh Trustee District

**HOUSE ACTION:** Ordered filed.



**JOHN O. BUTLER, M.D.,**  
Trustee

Dr. Dwight W. Schuster, the other ISMA Trustee representing the Seventh District, already has recounted the highlights of the district meeting held June 14 and there is no need for me to be repetitive. I shall confine myself, therefore, to a few brief observations.

Approval given to a small increase in district society dues should, in my opinion, allow the district better to promote its meetings and to encourage attendance. In the meetings, election of district representatives on the ISMA Board of Trustees and on the Board of Directors of Blue Shield, in themselves are of sufficient importance to warrant consideration by a large group of physicians.

In addition, improved financial resources should enable the district to pay adequate honoraria to speakers invited to discuss medical and socio-economic matters. The district meetings are another of the avenues of communication we need so sorely and which must be kept open.

I think it is incumbent upon district officers, as it is upon county society leaders, to keep the trustees advised of the thinking in their medical communities for, without direct contact, trustees can only guess as to the opinions of those they represent.

In part, district meetings were established because of the rigors of travel in earlier days and they gave members an opportunity to convene for mutual information and benefit when Indianapolis was far away. The attraction of the district meeting waned gradually until recent years when they again became an important forum and a real factor in state medical association affairs. I would urge that we keep them that way.

**JOHN O. BUTLER, M.D.**  
Trustee

## Eighth Trustee District

**HOUSE ACTION:** Ordered filed.



**RICHARD INGRAM, M.D.**  
Trustee

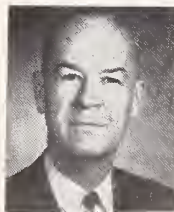
The Eighth District Medical Society had its annual meeting on Wednesday, June 7, at the Anderson Country Club. In attendance were a large number of physicians from all of the four counties represented in the Eighth District. Elections were held during the business meeting, at which time Dr. David Dietz of Muncie was elected Eighth District Medical Society President, Dr. Arthur Jay, also of Muncie, was elected secretary-treasurer of the Eighth District Medical Society. Further elections during that meeting included elections for trustees of the Eighth District. Dr. Richard Ingram was re-elected for another three year term, and Dr. Jack Alexander of Muncie was elected to fill the remainder of the unexpired term of Dr. R. B. Williams of Anderson, who had resigned his position. Other discussions were held during the business meeting but no other official business was transacted.

During the social and dinner hour the Eighth District Medical Society had as its honored guest Dr. Otis Bowen of Bremen, who talked with most of the guests personally, and later, following dinner, gave a very pleasant and instructive talk on the tax structure of the State of Indiana. It was felt that all benefited from his talk and enjoyed it as well. Fellowship was excellent and we are looking forward to a good meeting next year.

**RICHARD INGRAM, M.D., Trustee**

## Ninth Trustee District

**HOUSE ACTION:** Ordered filed.



**WILLIAM M. SHOLTY, M.D.,**  
Trustee

After two years as Ninth District Trustee, I am more and more aware of the workings of the ISMA and its struggle to maintain the freedom of medical practice as we have known it in the past. Socializing pressures come from many



directions.

The Ninth is the largest district, composed of 12 counties. As a result of my political activity in the primary election I was not able to visit all of the societies. I plan to visit each in the near future.

The Ninth District meeting was held on June 28 at the Ulen Country Club in Lebanon. Dr. Don Boyer served as president and Dr. Clarence Kern served as secretary. Dr. Peter Petrich, ISMA President, Dr. James Gosman, ISMA president elect, Mr. James Waggener, Executive secretary, and Mr. Howard Grindstaff, were in attendance. Due to an almost all-day rain, the attendance was down.

The afternoon program was given by Dr. Guy Owsley, Dr. Raymond Murray, and Dr. A. G. Popplewell. Dr. Owsley discussed Peer Review; Dr. Murray, HMOs; and Dr. Popplewell, Foundations.

At the business meeting Dr. Barton Bridge (Ninth District Blue Shield Board member) and Mr. Gary Miller discussed the problems of Blue Shield. Dr. Bridge urged all physicians to bring their Blue Shield problems to him.

Dr. Wemple Dodds of Crawfordsville was recognized as one of the founders of Blue Shield and one of the original members of the Blue Shield Board of Directors. When asked about their interest in forming Blue Shield, Dr. Dodds stated that a group of physicians from ISMA felt that a prepaid medical plan was needed for all patients. Yet, consideration to sponsor such a plan was turned down by some 33 insurance companies, and therefore they decided to form a plan of their own.

Dr. Lanning suggested that the ISMA Grievance Committee be referred to as the Public Relations Committee, in an attempt to better inform patients rather than have them seek legal advice.

Next year's meeting will be hosted by the Fountain-Warren County Medical Society.

We again plan to have a delegates dinner meeting prior to the ISMA annual meeting to discuss resolutions to be presented.

I want to thank my counties for their interest and cooperation. As trustee, I am aware of the tremendous struggle medicine must wage in order not to become completely socialized.

**WILLIAM M. SHOLTY, M.D.**  
*Trustee*

## Tenth Trustee District

**HOUSE ACTION: Ordered filed.**



**VINCENT J. SANTARE, M.D.,**  
*Trustee*

The 10th District now consists of two counties, Lake County and Porter County. Lake County revised its constitution and by-laws so that its officers will now hold terms of two years. Dr. D. T. Ramker was elected president for 1972-1973, Dr. Mitchell Goldenberg was elected vice-president and Dr. R. J. Bills was elected secretary. The Lake County Medical Society is electing its officers, trustees and delegates by ballot election which is being presented in the fall for the election in October for the offices to be assumed in January.

Meetings of the Lake County Medical Society were well attended as well as the 10th District meeting.

In Porter County, Dr. John Forchetti was elected president and Dr. Alfred J. Kobak was elected secretary. The Porter County Medical Society has set up a non-profit trust in order to collect monies and to distribute monies to the families of doctors who either, because of illness or death, are in financial difficulty.

Both County Medical Societies are active in comprehensive health planning and have officers serving on the Executive Committee.

The 10th District has elected Dr. Martin O'Neill of Valparaiso to succeed Dr. T. C. Tyrrell of Hammond as alternate trustee for the 10th District. Dr. Tyrrell did not run for re-election since he felt that he has held sufficient offices that it would be better for the welfare of the District to have an additional person serving as alternate trustee. Dr. William Fitzpatrick was elected director to the Blue Shield Board in the place of Dr. S. W. Shapiro.

The 10th District meeting, held in Hebron at the Lakes of the Four Seasons, was well attended and officers of the state association, Drs. Petrich, Gosman, Harshman, Senseny, and Mr. Waggener attended. Dr. Edward R. Annis gave the talk at this meeting.

The dues for the 10th District were raised an additional \$2.00 a year in order to be able to finance better district meetings in the future.

**VINCENT J. SANTARE, M.D.**  
*Trustee*

## Eleventh Trustee District

**HOUSE ACTION: Ordered filed.**



**LOWELL J. HILLIS, M.D.**  
*Trustee*

The annual meeting of the Eleventh Trustee District was held at the Mississinewa Country Club, Peru, on September 15, 1971.

This was one of the most outstanding meetings that has ever been held in this district. The afternoon discussion groups were well attended and there was active participation in the discussion by the members present.

The business meeting resulted in the election of Dr. John Elleman of Kokomo as president, Dr. Fred Poehler, LaFontaine as secretary-treasurer, and Dr. James Harshman as alternate trustee.

A beautiful steak buffet dinner was served and then was followed by the speaker, Dr. Edward Annis, Miami, Florida, past president of the American Medical Association and past president of the International College of Surgeons.

The speaker gave his usual presentation concerning the private practice of medicine. The evening program was broadcast live by radio station WSAL, and the tape was replayed later by stations WSAL-Logansport, WKMO-Kokomo and the Peru-Wabash radio station.

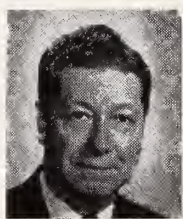
There have been no other activities within the district.

Great plans are again being made for the next district meeting September 20, 1972, at Kokomo.

**LOWELL J. HILLIS, M.D.**  
*Trustee*

## Twelfth Trustee District

**HOUSE ACTION: Ordered Filed.**



**WM. R. CLARK, SR., M.D.,**  
*Trustee*

During the past year I have met with some of my various Counties but have relied chiefly in relaying the happenings at the state level by editing a synopsis of the state trustees' meetings and having



this report posted in the various Ft. Wayne and county hospitals. Not only were the state trustee meetings events posted but also other reports of other medical meetings I attended. It seemed that in this way I could better inform each county society of the current monthly happenings.

These reports I personally went over with the Ft. Wayne Medical Society Board of Trustees at their monthly meetings. This, along with the postings in my Counties, has proven very effective in getting quickly to each District Member the solutions of the problems presented to the state board of trustees. I have urged that all members of ISMA peruse the reports of the ISMA Newsletter and the Journal.

We have had three meetings of the Executive Board that was established by the mandate of our new, recently adopted Constitution. These meetings, too, have proven effective in solving some of the Districts' problems.

This is the first year that we have tried having the Annual District Meeting in September. It is felt that having the Annual Meeting at this time would promote better attendance, in that it would not conflict with other District meetings, thereby giving a chance for more of our state officers to attend and doing away with the lame duck period of the elected trustee and alternate trustee.

This report is being written prior to the September 14 Annual Meeting, at which time officers will be named. Dr. Annis will be the guest speaker and we look forward to a fine and well-attended meeting.

I will continue to work for the best interests of organized medicine trying to give better patient health care and improving our professional image.

WILLIAM R. CLARK, SR., M.D.  
Trustee

## Thirteenth Trustee District

**HOUSE ACTION: Ordered filed.**



G. BEACH GATTMAN,  
M.D.,  
Trustee

The Thirteenth District Medical Society of the Indiana State Medical Association held its Annual Meeting at the Continuing Education Building on the campus of Notre Dame University, South

Bend, Indiana on September 8, 1971. An afternoon program on National Health Insurance-Medicaid was only moderately attended.

The business meeting was called to order by Dr. George Haley, President. Thirty-seven members were present. Dr. Otis Bowen, Thirteenth District Trustee gave his report, which included a comment on the lack of attendance at committee meetings. New officers elected were: Frank McGue, M.D., president (Michigan City); James Rimel, M.D., president-elect (Plymouth); David Spaulding, M.D., secretary-treasurer (Mishawaka); G. Beach Gattman, M.D., trustee (Elkhart); and Donald Chamberlain, M.D., alternate trustee (South Bend).

The dues of the Thirteenth District, which had been raised two years ago to \$2.00 per physician, seem to be adequate at the present time and it was decided to continue with the same dues.

Dr. Malcolm Scamahorn, President of the ISMA, attended as our guest.

Following cocktails and dinner, Mr. William Roose, Director of Drug Control, Indiana State Board of Health, spoke on "The Hoosier Drug Scene."

I have had the pleasure of attending the Christmas dinner meeting and dance of the LaPorte County Medical Society, and Dr. Chamberlain and I attended a joint meeting of the Starke-Pulaski County Medical Society at which Dr. Peter Petrich, president of the ISMA, gave the main address.

The officers of the District have been working on this year's District meeting and hope that the attendance will show a marked improvement.

G. BEACH GATTMAN, M.D.,  
Trustee

## Editor of The Journal

**HOUSE ACTION: Ordered filed.**

The financial accounts of *The Journal* this year will be approximately in balance with the budget. Some budget items will be long and others will be short, with the totals very close to standard figures. The advertising revenue for the first six months of 1972 is five percent above that for 1971.

The establishment of the Mary Rogers Fund within the Indiana Medical Foundation has been generously supported by gifts in memory of Mrs. Rogers who worked as editorial secretary for *The Journal* for many years. The income from this source was utilized this year to aid in the reproduction of the brush

painting by Dr. Wei Ping Loh for the July issue cover.

Special issues consisted of the Veneral Disease Program in November 1971 and the celebration of the 50th anniversary of the first clinical use of insulin in Indiana in the August issue this year.

A new feature was introduced in the form of a regular column on drug interactions. This is written by members of the faculty of Butler University College of Pharmacy through the cooperation of Dean K. L. Kaufman.

Medical history was recorded during the year in the form of a special issue which outlined the early medical history of Vincennes and Knox County, and by the account of the first use of insulin in this state in 1922.

Contributions, in the form of scientific and special articles, have been adequate and even generous, during the year. Acceptable scientific articles have been numerous enough to lengthen the time interval between acceptance and publication to a few months more than the customary six months. Additional revenue in the future will shorten the waiting period.

FRANK B. RAMSEY, M.D.  
Editor

## Delegates to AMA

**HOUSE ACTION: Ordered filed.**

The Indiana delegation to the American Medical Association's Annual Convention in San Francisco June 18 through 22 met long hours both during sessions of the AMA and after hours, to represent Indiana's physicians.

House of Delegates met for 17 hours and 20 minutes to act on 59 reports and 130 resolutions. These hours, of course, do not include the additional ones spent in reference committee meetings and caucuses of the delegation to consider the affairs of the national organization.

President Peter R. Petrich and President-Elect James H. Gosman met with the delegation throughout the four-day meeting. Chairman of the delegation was Dr. Eugene F. Senseny of Fort Wayne.

Delegates present were Drs. Frank H. Green, Rushville; James A. Harshman, Kokomo; Jack E. Shields, Brownstown, and Lowell H. Steen, Hammond.

Alternate delegates attending included Drs. Patrick J. V. Corcoran, Evansville; A. Alan Fischer, Indianapolis; Kenneth O. Neumann, Lafayette; Eugene S. Rifner, Van Buren, and Thomas C. Tyrrell, Hammond.



Also meeting in caucuses with the delegation were Drs. Guy A. Owsley, Hartford City, chairman of the AMA Council on Medical Service, whom the delegation nominated for vice president of the AMA; Myron H. Nourse, Indianapolis, delegate from the AMA Section on Urology; Lall G. Montgomery, Muncie, Section on Pathology, and Sprague H. Gardiner, Section on Obstetrics and Gynecology.

Among highlights of the meeting was the election of Dr. Russell B. Roth, speaker of the House, to the president-elect post of the AMA.

Other actions included approval of representation for medical students in the House of Delegates. In addition, results of the first AMA membership poll were presented to delegates—showing an overwhelming number of physicians endorsing AMA efforts to retain the basic principles of private practice in any government health program that might be enacted.

In his inaugural address, Carl A. Hoffman, president of the AMA, told the House of Delegates: "The cry for unionism is being raised in our profession as never before. There is no doubt that trade unionism has been an effective and valuable social instrument in our nation. But is it a proper activity for physicians to engage in?"

It is not, Dr. Hoffman said, because "unionism seeks its objectives through group power—and it achieves its power by carefully controlled conformity.

"This is the very objection we as a profession have raised against government-controlled medicine. The source of power of unionism lies in its ultimate weapon—the strike. A strike, even the threat of a strike, is a threat to withhold services. It is, therefore, a violation of medical ethics.

"Cynics may scoff, but millions of Americans still do enjoy a close personal relationship with their physicians," Dr. Hoffman declared.

On other matters, Dr. Hoffman said, "Peer review is an idea whose time has come. With the acceptance of the third party payor system, we accepted the ultimate necessity for certain controls by those who pay the bills. It is in the public interest—and in our own interest—to develop a flexible mechanism that is credible to the public, and does not lower the dignity of the profession. . . . Peer review was initiated by the profession itself."

Concluding, Dr. Hoffman addressed himself to younger members of the

House and to new physicians in general. He said he believed in years to come they would find that "this association alone represents American medicine." And as our society becomes more complex and the government larger, "there is an even greater need for institutionalized power outside of government," he said.

The House received, and adopted, results of the first membership opinion poll on critical issues affecting the practice of medicine. The overwhelming majority of 94,000 respondents (73.1%) recommended that AMA continue to seek to retain the basic principles of private practice in any government enacted health program. And more than half (55.7%) preferred the AMA plan of national health insurance over all others. The AMA plan was four times as acceptable as the next most preferable option, which was catastrophic coverage only (14.1%). If compulsory health insurance were adopted, 28.1% of respondents said they would continue private practice "with those patients who would pay my private fees" and 24.6% said they would "join the federal program and continue to practice under it." Many (21.6%) were undecided as to what they would do.

On the work of the Association, programs which received the greatest percentage of responses indicating "not enough" emphasis were: communications to the public (62.5%); practice management problems (39.8%) and socioeconomic issues (35.1%). A majority of members indicated that AMA was placing "proper" emphasis on: scientific activities (66.3%); medical education (67.9%); continuing education (63.3%); membership benefits (51.8%) and communication to the medical profession (55.2%).

The questionnaire went to 177,882 non-federally employed members and 94,035, or 52.9%, questionnaires were returned. The questionnaire also was sent to a random sample of 4,500 members, including federal physicians, and a random sample of 3,000 non-members of the AMA to test sampling techniques as a possible tool for use in future surveys.

Reflecting concern for "potential problems which could arise," the House approved a policy opposing employment of physicians' assistants in hospitals. The move was recommended by the Council on Health Manpower and the Board of Trustees, through Board Report B.

Also adopted was Board Report Z, proposing guidelines for compensating physicians for services of physicians' assistants. It urged legislation to empower

state boards of medical examiners to approve a physician's employment of an assistant and to approve proposed functions of the assistant, as described by his employer. Reimbursement for assistant's services should be made directly to the employing physician, the report said.

Also adopted was Board Report F, dealing with education and utilization of allied health manpower. Some of its recommendations urged AMA to:

1. Continue to support efforts to increase the number and improve the utilization of medical, nursing and allied personnel until 1975, with re-evaluation then on the need for further efforts.

2. Continue to support improvement of the professional and financial potential of allied health careers.

3. Continue efforts to expand allied health career opportunities for minority and disadvantaged groups.

4. Strongly reaffirm support of an expanded role for the nurse in providing patient care, and study the nurse's role in relation to the physician assistant, so the two professions can complement rather than duplicate one another.

The House refused to accept the statement in Board Report J which said, "possession of marihuana for personal use and transfer (not sale) of insignificant amounts should not be criminal acts." After extensive debate, this substitute recommendation was adopted:

"This AMA House of Delegates does not condone the production, sale or use of marihuana. It does, however, recommend that the personal possession of insignificant amounts be considered at most a misdemeanor with commensurate penalties applied."

The substitute recommendation continued (in agreement with the original): "(The House) also recommends its prohibition for public use; and that a plea of marihuana intoxication should not be a defense in any criminal proceeding."

Delegates approved a strong resolution aimed at any independent determination of customary physicians' fees:

"Resolved, that where benefits include physicians' fees, management, labor and third party carriers shall consult with duly constituted representatives of organized medicine before determining 'usual, customary and reasonable fees,' the measure said.

The resolution was adopted in lieu of several others, all protesting actions of Aetna Life and Casualty Insurance Company. It added:

"The medical profession will not condone or tolerate action on the part of



any third party that would encourage or promulgate litigation in the settlement of any such dispute." This referred to a practice of telling policy holders that—except where there was prior agreement between patient and physician as to the fee—the insurance company would pay the patient's legal costs if the physician sued to collect his full fee.

The resolution also reminds physicians "that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered."

The House approved acceptance of a new contract with the Fireman's Fund Insurance Co. to continue the AMA Group Disability Insurance Program (Board Report M). The contract is to run five years, ending Sept. 1, 1977, although the program is not guaranteed beyond Sept. 1, 1974. There will be no increase in premium, but benefits will be reduced by 50 per cent from age 65 through 69, and an additional 50 per cent at age 70, remaining at that level for life. The amount of benefits payable for accidents will be reduced the same as sickness benefits. The Board said Fireman's Fund insisted on the change and that no alternate carrier could be found.

Paul Dudley White of Boston, internationally famed heart specialist, received the fifth annual Sheen Award (including a check for \$10,000) for outstanding contributions to medicine.

JAMES A. HARSHMAN, M.D.  
EUGENE F. SENSENY, M.D.  
FRANK G. GREEN, M.D.  
JACK E. SHIELDS, M.D.  
LOWELL H. STEEN, M.D.

Maternal Mortality  
Study Committee

HOUSE ACTION: Ordered filed.

The Maternal Mortality Study Committee operated under a new arrangement during the past year. William D. Ragan, M.D., member of the Staff of the Department of Obstetrics and Gynecology, Indiana University School of Medicine, obtained information and prepared cases for the Committee's review. Expenses incurred were met by a grant from the Indiana State Board of Health to the Indiana University School of Medicine. This arrangement has made the work of the Committee more effective. Dr. Ragan has been available for presentation of information to medical staff meetings and has used the material from the Committee for teaching. Confidentiality of cases is maintained. Two

articles on maternal mortality in Indiana have been prepared and have been presented to the Indiana State Medical Association for publication in *The Journal*.

The Committee had two meetings during the year at which 22 cases were reviewed. It is planned to publish in-

formation on the findings in the coming issues of the *ISMA Journal*.

It is felt that, under the present operation of the Committee, information will be better disseminated to physicians and thereby contribute to improved maternal care in the State.

REPORT OF BOARD OF MEDICAL  
REGISTRATION AND EXAMINATION OF INDIANA  
July 1, 1971, to June 30, 1972

<b>HOUSE ACTION: Ordered Filed.</b>		Candidates, Podiatry, failed ..... 0			
Applications received for December, 1971, June 1972 State Board Examinations (Med.) .....		TOTALS, LICENSED BY EXAMINATION			
Ineligible to take State Board Examination for various reasons....		1969-1970 1970-1971 1971-1972			
Approved for December, 1971, June, 1972 State Board Examinations .....		Medicine	355	284	287
Failed to appear for State Board Examinations .....		Physical Therapy	23	41	43
Applicants taking State Board Examinations .....		Physical Therapist's Assistants	0	0	24
Candidates failed the State Board Examinations .....		Podiatry	11	2	6
Candidates from Indiana University Medical School taking State Board Examinations .....		Osteopathy	1	0	0
Candidates from Indiana University Medical School taking State Board and failed .....		Chiropractic	0	0	0
Candidates taking Doctor of Osteopathy Examination .....		1969-1970 1970-1971 1971-1972			
Candidates taking Doctor of Osteopathy Examination, failed .....		Applicants granted license in Indiana by endorsement/reciprocity (M.D.)			
Candidates from foreign medical and other schools taking State Board Examinations .....		181 184 265			
Candidates from foreign medical and other schools, failed .....		Applicants endorsed to other states (M.D.)			
Over-all failure rate .....		309 332 205			
I.U.M.S. Graduate, failure rate .....		Applicants granted license in Indiana by endorsement/reciprocity			
Foreign medical school graduate, failure rate .....		(Osteopathy) 10 5 12			
Candidates taking Chiropractic State Board Examination .....		Applicants endorsed to other states (Osteopathy)			
Candidates taking Physical Therapy Examinations .....		2 0 2			
Candidates taking Physical Therapy Examinations, failed .....		Applicants granted Physical Therapy license in Indiana by Endorsement/reciprocity			
Candidates taking Physical Therapist's Assistants Examination .....		22 20 18			
Candidates taking Physical Therapist's Assistants Examination, failed .....		Physical therapists endorsed to other states			
Candidates taking Podiatry State Board Examination .....		7 7 16			
Candidates taking Podiatry National Board Examination, licensed ..		Applicants granted Chiropractic License in Indiana by endorsement/reciprocity			
		13 11 16			
		Chiropractors endorsed to other states			
		0 0 0			
		Applicants granted Podiatry license in Indiana by endorsement/reciprocity			
		2 0 0			
		Podiatrists endorsed to other states			
		0 1 1			
		Citations or Board Action during the year (all groups)			
		12 14 7			
		Revocations during the year (all groups)			
		4 1 6			
		Licenses reinstated			
		1 0 63			



Physicians, voluntarily surrendering  
their Narcotic Stamp to the Internal  
Revenue Department

4                      0                      3

# TOTALS, BOARD LICENSURE:

1969-1970    1970-1971    1971-1972

M.D. (resident and non-resident)	8,025	8,248	8,617
D.O. (resident and non-resident)	276	271	279
Drugless (resident and non-resident)	139	140	143
Chiropractic (resident and non-resident)	338	342	349
Physical Therapy	356	379	410
Podiatry	189	212	214
Midwife	3	3	4
Physical Therapist's Assistants	0	0	24
Temporary Physical Therapy Permits issued	7	3	4
Temporary Medical Permits issued	70	28	14
Internship Permits issued	158	102	116
Temporary Medical Educational Permits issued	50	44	45
Temporary Physicians Permits issued	13	31	89
Medical Teaching Permits issued	9	5	8
Total Medical Corporations Licensed in Indiana	207	305	517
Total Chiropractic Corporations Licensed in Indiana	0	0	1
Total Podiatry Corporations Licensed in Indiana	0	0	1

## Reports of Standing Committees and Commissions

### Executive Committee

#### HOUSE ACTION: Ordered filed.

The Executive Committee met for organization purposes upon the conclusion of the meeting of the Board of Trustees following the final session of the House of Delegates on October 14, 1971.

At that time Dr. Donald Kerr was by secret ballot elected chairman of the

committee and Dr. James H. Gosman was welcomed as a new member of the committee by virtue of being elected president-elect of the Indiana State Medical Association.

The committee met again on November 13, 1971, at which time they received a report from the federal government complimenting the handling by the ISMA of the CHAMPUS program.

The committee heard a report from the Woman's Auxiliary concerning their proposed Nursing Home Visitation program and this matter was referred to the Board of Trustees.

The committee referred material concerning foundations to the Future Planning Committee with the request that they make a thorough investigation of foundations and make their recommendations to the Association.

As a result of the survey of the membership, the committee received information from the IMMKE Leasing Company concerning a car leasing program for members of the Indiana State Medical Association and this was referred to the Board of Trustees.

Matters relating to Blue Shield were discussed.

The dates for the 1972 meeting were finalized with recommendation that the meeting be held at the Convention Center, which was also named as the Headquarters for the 1972 meeting.

The committee approved the purchase of the Chamber of Commerce Legislative Reporting Services to be used by the staff and the Commission on Legislation.

A release prepared by the Headquarters staff was approved for use by the Fayette-Franklin Medical Society in case the county society desired to use it.

Several matters dealing with the 1971 Clinical Session of the American Medical Association were also reviewed.

The committee heard a presentation by Dr. Bonsett concerning the transformation of the old Pathology Building on the Central State Hospital grounds as a Medical Historical Center and a Museum for early Indiana Medicine. This matter was referred to the Board of Trustees to determine if the Indiana State Medical Association would be interested in participating in this effort.

The committee also heard a presentation by Mrs. Chernish, president of the Woman's Auxiliary, concerning the installation of a kitchen facility in the building, and this was referred to the Board of Trustees.

The committee convened again on

December 15th and received a report from the AMA meeting that interns and residents would be expected to pay an additional \$20 in dues if they desired to belong to the AMA. It was taken that we would not bill for the '72 dues in view of the fact that billings had already been mailed, but the secretary was instructed to inform interns and residents they could join the AMA by paying an additional \$20 if they so desired.

A report from the Commission on Voluntary Health Agencies requesting that the Yearbook issue list only the Voluntary Agencies which had been approved by the Commission was accepted.

The committee planned for a joint meeting with representatives of the osteopathic association to be held in January of 1972.

Membership in the Better Business Bureau was renewed.

Membership in the Indiana State Chamber of Commerce was also renewed.

A letter of approval from Dr. Offutt concerning the proposed Visitation of Nursing Homes Program by the Auxiliary was reviewed and the Visitation Program was then approved by the committee.

Minutes of the Blue Cross and Blue Shield Boards were reviewed.

The committee heard a report from the executive secretary that the expense of holding the meeting at the Convention Center would in all probability exceed those paid formerly in the occupation of the Murat Temple.

The committee approved a proposed bill concerning Health Careers and also approved distribution of a bibliography of publications dealing with Service Systems for Delivery of Health Care.

Representatives were selected by the committee for various meetings to be held by the AMA and other organizations in which the committees of the Association would have a vital interest.

The committee was visited by representatives of a county medical society for a discussion of a lawsuit which had been instituted against several physician members of that society.

The committee then met with representatives of the Indiana Nurses Association, the optometric association and the pharmaceutical association for a discussion of a proposed bill to certify physicians' assistants.

The next meeting of the Executive Committee was held on January 8, 1972, and the committee again heard a presentation by Doctor Bonsett and again this



was referred to the Board of Trustees.

The committee approved the purchase of dishes for the kitchen by the Auxiliary.

A proposal for a tour by members of the Association was reviewed and it was ordered sent to the legal counsel for legal opinion before signing.

Welfare matters concerning the de-certification of some Indiana physicians as providers under Title XIX Act was reviewed and a letter from the Welfare Director addressed to the Indiana congressional delegation expressing dissatisfaction with the handling by HEW of Title XVIII and XIX programs was reviewed and the committee voted to commend Mr. Sterrett on his letter.

The committee took action to recommend that Reference Committees also be titled so as to indicate the type of business which would be considered by them and also voted to recommend to the Board of Trustees that they submit a resolution to the 1972 House of Delegates requiring fiscal notes be attached to all items calling for expenditure of association funds.

It was also voted to recommend to the Board of Trustees that a resolution be prepared to give the medical students a vote in the House of Delegates.

The next meeting of the Executive Committee was held on March 4th. The committee received requested changes in the Bylaws of the Indiana Medical Assistants organization and the changes were approved.

The committee voted to assist the SAMA organization of Indiana by a contribution to help defray the expenses of their delegates to their national meeting.

The attorneys' opinion concerning the doctor's liability in the Consumer Code was reviewed.

The committee received a report from the Commission on Emergency Medical Services of a proposed policy statement on the training of emergency medical personnel and this was referred to the Board of Trustees with the recommendation that it be approved.

The committee voted to recommend that Dr. J. O. Ritchey be nominated to receive the Sheen Award.

Plans for the promotion of the candidacy of Dr. Guy A. Owsley for vice president of the American Medical Association were reviewed.

A request from Blue Shield for revising member fees for the physicians' program was reviewed and referred to the Board of Trustees.

An attorney's opinion concerning the

liability of a physician in the drawing of blood under Indiana's implied consent law was reviewed and the secretary was instructed to distribute this information widely.

The secretary reported that, as suggested, he had received bids for the printing of *The Journal* and the committee voted to refer this to the Board of Trustees with the recommendation that the Journal be printed by the Gibbs-Inman Company of Louisville, Ky., beginning with the July issue.

The committee set up the guidelines for operation of the Indiana room at the San Francisco meeting of the AMA.

The committee met again on April 6th.

A letter was received from the Vanderburgh County Medical Society withdrawing their request for holding the 1974 annual meeting in Evansville. The letter was accepted.

The committee reviewed a tentative program for the joint meeting of the Indiana Hospital Association and the Indiana State Medical Association for hospital administrators, chiefs of staff and trustees.

The committee voted to increase the limit on travel insurance for commission and committee members and officers of the association traveling on business of the association, the limit to be increased from \$50,000 to \$100,000 for accidental death or dismemberment.

Membership in the U. S. Chamber of Commerce was renewed.

Blue Cross-Blue Shield coverage of association employees was renewed.

A letter was received from the A. H. Robins Company together with a check for \$200 to be used as the Indiana State Medical Association saw fit in development of professional or scientific matters and the matter was referred to the Board of Trustees for acceptance or rejection.

The guest list for the 1972 annual convention was approved.

The committee discussed the use of the Medical Defense Fund and it was voted to suggest to the Board of Trustees that they present a resolution to the House setting a top limit of \$2,000 per case.

The committee convened again on June 10, 1972.

The contract for the charter trip to the Orient was approved and signed.

The secretary discussed the remodeling of the office space in the headquarters building and presented bids for the work. The secretary was instructed to proceed and the lowest bid was accepted.

The secretary reported he had received an overture from the Regional Medical Planning group to use Indiana State Medical Association's field staff jointly with the RMP and that possibly funds would be available from RMP to employ additional field staff. The Executive Committee approved this proposal and referred it to the Board of Trustees.

The secretary raised a question concerning Chapter 4, Section 2 of the Bylaws concerning delegates to the state convention and this matter was referred to the Board of Trustees.

The committee heard a complaint from a physician concerning the election held by the Fourth District Medical Society and this was taken as a matter of information.

The secretary presented a pamphlet entitled "Misconceptions of Medicare" developed by the Illinois State Medical Society with permission to reproduce it. The idea of duplicating this for use by Indiana physicians was approved and referred to the Board of Trustees.

The secretary raised a question concerning military members and this matter was referred to the Commission on Constitution and Bylaws.

The committee voted to send information to the newly appointed Building Committee that they plan now for the expansion of the existing building.

The audit of the Medicaid operation by the Legislative Council was called to the attention of the committee.

The secretary presented an opinion from the attorneys on the subject of usual and customary fees.

A court decision of the Missouri Supreme Court was read which might have the effect of declaring all doctors in violation of the Missouri law in the use of medical assistants or other type of ancillary personnel.

Opinions were expressed at the request of the Legislative Advisory Committee concerning a proposed law dealing with physicians' assistants and ancillary personnel.

At the request of Oscar Ritz, state insurance commissioner, an association representative was named to represent ISMA on a committee for the study of HMOs.

The above are merely a few of the matters which came before your Executive Committee and complete copies of all the minutes are in the hands of the Reference Committee for their review.

In addition, the committee reviewed the financial situation of the association



at each of its meetings, as reported by the treasurer, as well as the membership report and the requests for medical defense by physicians who have been sued for malpractice.

Reports on Medical Defense activities, *The Journal* and the Membership Report are as follows:

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1, 1971, the following two cases were pending before the committee:

- Case 307—Suit filed March 22, 1962. Pending. (Expense to date, \$1,-042.73)
- Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1971 and to August 1, 1972, three new cases have been filed.

2. Medical Defense Fund Statement from August 1, 1971, to August 1, 1972:

Bank balance,	
August 1, 1971	\$8,175.35
Receipts	8,787.76
Total cash and receipts	
August 1, 1972	\$16,963.11
Disbursements	None
Balance on hand	
August 1, 1972	\$16,963.11

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1972, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116

The table below shows the total printing costs of *The Journal*

Year	Total Printing Cost	No. of Pages (Inserts Excluded)
1967	\$49,958.15	1450
1968	50,709.62	1462
1969	42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972 (6 mos.)	22,051.53	716

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1972, is as follows:

State	1968	1969
Medical	*24,153.24	17,086.59
Journal Adv.	**7,200.10	2,557.80
Bureau*	31,353.34	19,644.39

	1970	1971	1972
Sold direct	15,791.12	13,128.30	17,869.96
by Journal**	2,268.80	1,821.89	1,622.60
Totals	18,059.92	14,960.19	19,492.56

MEMBERSHIP REPORT

Total Members	December, 1970	December 1971
ISMA	4,505	4,554
AMA	4,337	4,293

	July 31, 1971	July 31, 1972	
ISMA	4,489	4,526	+37
AMA	4,236	4,179	-57

DISTRICT REPORT AS OF JULY 31, 1972

+ GAIN - LOSS DISTRICT	ISMA	AMA
1	+ 4	- 3
2	+ 2	+ 1
3	+15	+11
4		-10
5	- 5	- 7
6	+ 2	- 3
7	+17	- 9
8	+16	+ 1
9	+ 3	- 2
10		- 2
11	- 3	- 7
12		- 5
13	-14	-22
	+37	-57

TOTAL NEW MEMBERS

DISTRICT	AS OF JULY 31, 1972
1	8
2	4
3	20
4	10
5	5
6	5
7	32
8	14
9	5
10	29
11	10
12	10
13	12
	164

DEATHS

December, 1971	As of July 31, 1972
54	30

MEMBERSHIP REPORT

	Dec. 31, 1971 ISMA	July 31, 1971 ISMA	July 31, 1972 ISMA	July 31, 1972 AMA
1st DISTRICT				
Gibson	11	11	11	11
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	5	5
Vanderburgh	259	251	256	242
Warrick	7	7	6	6
TOTAL	297	289	293	279

2nd DISTRICT				
Daviess-Martin	18	17	18	11
Greene	16	16	16	10
Knox	39	39	41	40
Owen-Monroe	91	88	89	80
Sullivan	12	12	10	9
TOTAL	176	172	174	150

3rd DISTRICT				
Clark	48	47	53	47
Dubois	27	27	26	22
Floyd	45	45	44	44
Harrison-Crawford	9	9	9	9
Lawrence	29	28	37	29
Orange	7	7	8	8
Scott	5	5	7	7
Washington	8	8	7	6
TOTAL	178	176	191	172

4th DISTRICT				
Bartholomew-Brown	56	56	61	49
Dearborn-Ohio	17	16	15	14
Decatur	13	13	10	9
Jackson-Jennings	21	21	19	18
Jefferson-Switzerland	29	29	29	23
Ripley	10	10	11	9
TOTAL	146	145	145	122

5th DISTRICT				
Clay	13	13	10	10
Parke-Vermillion	17	17	15	15
Putnam	19	19	18	18
Vigo	119	118	119	115
TOTAL	143	167	162	158

6th DISTRICT				
Fayette-Franklin	15	15	16	16
Hancock	27	27	27	27
Henry	38	38	38	33
Rush	13	13	12	12
Shelby	21	20	21	17
Wayne-Union	71	69	70	63
TOTAL	185	182	184	168

7th DISTRICT				
Hendricks	23	23	22	18
Johnson	36	36	36	34
Marion	1081	1057	1075	1047
Morgan	21	21	21	19
TOTAL	1161	1137	1154	1118

8th DISTRICT				
Delaware-Blackford	125	119	128	101
Jay	16	16	16	13
Madison	102	101	108	75
Randolph	17	17	17	13
TOTAL	260	253	269	202

9th DISTRICT				
Benton	9	9	10	9
Boone	17	17	18	18
Clinton	14	14	14	11
Fountain-Warren	11	11	11	10
Hamilton	16	16	14	10
Jasper	8	8	8	8
Montgomery	21	21	22	22
Newton	5	5	5	5
Tippecanoe	150	148	142	132
Tipton	11	11	11	11
White	7	7	7	6
TOTAL	269	267	262	242

10th DISTRICT				
Lake	456	447	450	414
Porter	64	62	67	65
TOTAL	520	509	517	479

11th DISTRICT				
Carroll	8	8	8	8
Cass	39	38	35	29
Grant	76	76	79	78
Howard	70	70	70	68
Huntington	19	19	18	17
Miami	13	13	13	12
Wabash	31	31	29	22
TOTAL	256	255	252	234



## 12th DISTRICT

Adams	13	13	12	12
Allen	311	310	311	283
DeKalb	20	20	19	15
LaGrange	11	11	11	9
Noble	12	12	12	12
Steuben	10	10	10	10
Wells	39	39	40	40
Whitley	15	15	15	15
TOTAL	431	430	430	396

## 13th DISTRICT

Elkhart	113	111	111	102
Fulton	6	6	7	6
Kosciusko	14	14	12	12
LaPorte	98	97	93	78
Marshall	25	25	20	18
Pulaski	4	4	5	1
St. Joseph	243	242	237	235
Starke	8	8	8	7
TOTAL	511	507	493	459

## SUMMARY

1st DISTRICT	297	289	293	279
2nd DISTRICT	176	172	174	150
3rd DISTRICT	178	176	191	172
4th DISTRICT	146	145	145	122
5th DISTRICT	168	167	162	158
6th DISTRICT	185	182	184	168
7th DISTRICT	1161	1137	1154	1118
8th DISTRICT	260	253	269	202
9th DISTRICT	269	267	262	242
10th DISTRICT	520	509	517	479
11th DISTRICT	256	255	252	234
12th DISTRICT	431	430	430	396
13th DISTRICT	511	507	493	459
	4,558	4,489	4,526	4,179

DONALD M. KERR, M.D., *Chairman*  
 WILBERT McINTOSH, M.D.  
 PETER R. PETRICH, M.D.  
 JAMES H. GOSMAN, M.D.  
 JOSEPH DUKES, M.D.  
 LESTER H. HOYT, M.D.  
 HUGH K. THATCHER, JR., M.D.

## Grievance Committee

### HOUSE ACTION: Ordered filed.

The Grievance Committee met on November 21, 1971, and July 9, 1972. Few complaints were received, which is an indication to the committee that the county medical societies are doing a better job in handling complaints at the local level and they are to be commended for this. The two most prevalent complaints received by the committee are those of a misunderstanding of charges by physicians and the lack of communication between the patient and the doctor.

As of August 1, 1972, 10 new cases were filed, three of which have been referred to the local county medical society. Eight complaints were received in which no authority was given by the complainant to forward a copy of the complaint to the physician named.

As mandated by the 1967 House of Delegates, the Purposes, Rules and Procedure of the Grievance Committee has been revised and was printed in the January 1972 *Journal* of the ISMA.

We wish to call attention to the Grievance Committee recommendations

of the St. Joseph County Medical Society which will help avoid grievances. Our committee felt these recommendations should be published in *The Journal* and we wish to incorporate them in the annual report of the House of Delegates.

1. Do not charge for calls unless they are actually made by the physician or his substitute.

2. When a substantial charge is made for service, such as a foot strapping, injection of bursa, application of cast, etc., we would suggest that the charge cover the office call as well as the particular service rendered, rather than to submit an additional charge for the office call.

3. The surgeon should not charge for postoperative hospital visits up to a reasonable limit, if they are part of the normal care. Neither should the attending or referring man make charges unless there is an actual medical problem to be managed.

4. If procedures are likely to require charges which would seem excessive to patients, discussion of the procedure and the fee for such would be appropriate to avoid misunderstandings. This involves surgical procedures, special procedures by medical specialists and by anesthesiologists. Furthermore, if certain procedures will require a long anesthetic, the patient might be forewarned, so that he may anticipate an appropriate charge for the anesthesia.

5. The need for hospitalization should be verified by the physician before he admits the patient to the hospital.

6. Communication breaks have created problems resulting from:

- Refusal to itemize statements.
- Refusal to communicate with patient by letter or by phone.
- Discourteous conduct toward patients, including refusal to review materials submitted by patients, discussion of patient in front of nurses, careless discussion of patients on ward rounds while in the presence of the patient, failure to inform patient of diagnosis and to give appropriate advice, and inappropriate discharge of patients from hospital before the patient is adequately informed of the diagnosis and followup measures.
- Unwillingness to discuss fees with patients when requested.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging

its responsibility.

JOHN M. PARIS, M.D.,  
*Chairman*  
 KENNETH WILHELMUS, M.D.,  
*Secretary*  
 WALLACE R. VAN DEN  
 BOSCH, M.D.  
 KENNETH L. OLSON, M.D.  
 WILLIAM D. PROVINCE, M.D.  
 EUGENE S. RIFNER, M.D.  
 RICHARD S. BLOOMER, M.D.  
 ROBERT G. YOUNG, M.D.

## Future Planning Committee

### HOUSE ACTION: Ordered filed.

Your Future Planning Committee has met on several occasions and submits the following report for consideration of the House of Delegates.

After extensive discussion, the Future Planning Committee recommends that all county medical societies extend their efforts to assure that every physician in every county in Indiana become a member of ISMA and the American Medical Association. Whatever steps are necessary to recruit these individuals should be taken to broaden our physician participation. Particular attention was given to ISMA non-membership of the faculty of the Indiana University School of Medicine. President-elect James H. Gosman, M.D., indicated that he would make this a personal crusade.

In view of growing changes in the military medical dependents' program, it is probable that the Indiana State Medical Association may be called upon to process an increasing number of claims under the CHAMPUS program. Also, the Indiana State Medical Association is constantly expanding its many programs and services, most notable of which is the increased use of the facilities by various special societies. The Future Planning Committee can foresee a time when a need for additional space will become critical. It was therefore, recommended that the president appoint a building committee to begin investigation and discussion of future expansion of the headquarters facilities.

Foundations were discussed and, by unanimous consent, it was agreed to recommend to the Board of Trustees of ISMA that the Indiana State Medical Association establish a statewide foundation, on paper, if nothing else. Further discussion of this matter grew at the most recent joint meeting of the Committee on Future Planning and the Commission on Medical Economics and Insurance. (Please see joint report of the



Commission and the Committee elsewhere in this issue.)

The Executive Secretary's report to the House of Delegates of the 1971 Convention was referred to the Future Planning Committee for discussion and recommendation. The Committee commends Mr. Waggener for the excellence and comprehensiveness of his report. As a result of this view the following actions were taken.

The Committee recommended to the Board of Trustees that they immediately give the Executive Secretary permission to employ one additional person for the purpose of handling legislation, government and public affairs and, further, it was recommended that the Committee felt even additional personnel would be needed in the very near future to fulfill the obligations of the Association to its membership, commissions and committees. We further recommended that the Board consider employment of an additional individual or two as soon as appropriate budgeting and financial arrangements could be accomplished to meet this manpower demand.

Attention was directed to the Medical Disciplinary Act that had been passed unanimously by the House of Delegates in 1970 and was held up by the Board of Trustees who had been unable to agree on some of the wording. The rewording was placed before the Delegates at the 1971 meeting; they approved the introduction of the legislation to the 1972 session. Subsequent to this, the Commission on Legislation took a position not to introduce the bill at this time and it was, therefore, not introduced. It was the feeling of the Future Planning Committee that such an act should have been placed before the 1972 session of the legislature to cure many of the problems of discipline among physicians in the State of Indiana. It was the unanimous opinion of the Future Planning Committee that this bill definitely be introduced to the 1973 session without hesitation or delay. It was reported that several legislators are extremely anxious to sponsor this bill on a bipartisan basis.

It is the opinion of the Future Planning Committee that suggestions for long-term change and suggestions which may be of long-term importance to the Indiana State Medical Association be forwarded to it by other commissions, committees, individual members and by our delegates and individual members of the Indiana State Medical Association. Submitted by,

- LOWELL H. STEEN, M.D.,  
Chairman
- STANLEY CHERNISH, M.D.
- MAURICE E. GLOCK, M.D.
- JAMES FITZPATRICK, M.D.
- RALPH V. EVERLY, M.D.
- PATRICK J. V. CORCORAN, M.D.
- GEORGE M. HALEY, M.D.
- CHARLES GILLESPIE, M.D.
- LESLIE BAKER, M.D.
- MALCOLM O. SCAMAHORN, M.D.  
(ex-officio)
- PETER R. PETRICH, M.D. (ex-officio)
- DONALD M. KERR, M.D. (ex-officio)
- FRANK B. RAMSEY, M.D. (ex-officio)
- JOE DUKES, M.D. (ex-officio)

Student Loan Committee

HOUSE ACTION: Ordered filed.

The Student Loan Committee did not have a formal meeting the past year. However, two telephone and letter meetings were held regarding the obvious default of one of the loans which, in due time, was resolved by the payment in full of the loan.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the Association has on deposit with the bank \$20,810 to guarantee loans totaling \$260,000. As of July 31, 1972, 108 loans totaling \$95,500 have been granted under this plan. During this year 31 loans have been converted to installment loans in the amount of \$30,971.00; one loan totaling \$700 has not been converted; 17 loans have been paid in full during this year.

A report on the Loan Fund which was under the Association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	\$58,458.36
Total repaid by loanees as of	
July 31, 1972.....	58,386.60
Total amount outstanding,	
July 31, 1972	\$ 71.76
Of the 117 who received loans,	
116 have repaid in full	
1* is making payments	
*Total due on above loan still	
outstanding .....	\$ 71.76

As previously reported, two loans under the Guaranteed Loan Plan were defaulted, one in the amount of \$606.54 and the other, \$1,913. The Indiana National Bank was reimbursed for these notes. We wish to report that the Association has received \$754.28 from the estate of the physician whose loan was \$606.54, and regular payments are being received from the physician whose

loan amounted to \$1,913.  
The Student Loan Committee is surprised that there were no applications for loans from October 1, 1971, to July 31, 1972. Despite this fact, it is our feeling that the Student Loan Program does provide financial help to needy students. However, we know that low interest rate loans, no interest loans and federal grants are currently available to students.

- MALCOLM O. SCAMAHORN, M.D.  
Chairman
- PETER R. PETRICH, M.D.
- JOE DUKES, M.D.
- JAMES O. RITCHEY, M.D.
- LESTER H. HOYT, M.D.
- GLENN W. IRWIN, JR., M.D.

Joint Medical-Legal Review Committee

HOUSE ACTION: Ordered filed.

The Joint Medical-Legal Review Committee met March 15, 1972, with all medical and two legal members in attendance.

The committee has received no official complaints this year.

The amendment to improve the practical implementation of the inter-professional code has been approved by the House of Delegates of both the Indiana State Medical Association and the Indiana State Bar Association. The Code has since been reprinted in the Indiana State Medical Association's *Journal*. A large supply of reprints was obtained which the committee recommended should be distributed to new members and to grievance committee members of each association and, if possible, to the Judges in the State. The Indiana State Bar Association will reimburse the Indiana State Medical Association for those reprints it requires for its members.

We feel that the above measures will serve to better inform the membership of each association that the Joint Medical-Legal Committee is functioning and ready to hear complaints and, perhaps, will have a beneficial influence upon the conduct of members of both professions.

Dr. Beeler and Mr. Segar are planning to have a joint meeting between physicians and attorneys in Marion County, particularly, in an effort to come to a better understanding on the medical malpractice problems in this state, and they may extend an invitation to all members of both associations throughout the state.



JOSEPH WEBER, M.D.

Chairman

JOHN W. BEELER, M.D.

ROBERT R. KOPECKY, M.D.

MR. ROBERT WATERS (SAMA)

## Finance Committee

**HOUSE ACTION:** Approved. Resolution included in report adopted.

The Board of Trustees of the Indiana State Medical Association has voted to recommend to the House of Delegates that the annual dues of the association be increased by \$10, making the dues \$110 effective January 1, 1973.

A resolution to this effect will be presented to the House of Delegates at the 1972 annual meeting in Indianapolis October 15 to 18.

To inform the membership of the necessity for this increase, the Board directed that information be made known to ISMA members through their county medical societies; therefore, a copy of this is being sent to the president and secretary of each county medical society, as well as to the delegates to the state convention.

Factors which have brought about the necessity for a dues increase:

(1) **GENERAL INFLATION** has hit almost every phase of organization operation and activities.

(2) **POSTAGE.** Postage is an all important factor in communication with the membership. This cost has tripled between '65 and '72.

(3) **INCREASED BUILDING EXPENSE.** As our building grows older upkeep and repairs gradually cost more.

(4) **LEGAL FEES.** With the increased intervention of government in the practice of medicine, legal problems become more complex and more numerous. As the association becomes engaged in more and more activities, legal fees will increase substantially.

(5) **INCREASED SALARIES.** The cost of living salaries will amount to an increase in the payroll. In addition, the 1971 House of Delegates approved the employment of an additional individual and referred this to the Board of Trustees for implementation. This will also require additional expenditure of funds which can only be met by an increase in dues.

The headquarters office at present is inadequately staffed to undertake the activities and services directed by the House of Delegates; Board, the various Commissions and Committees.

(6) **MEETING COSTS.** The income from sale of exhibit space during the past several years has shown a decline while expenses of conducting the annual meeting have increased. For example, in 1966 our income from the sale of exhibit space was \$29,947.75, with the expense of that year's meeting being \$31,164.64. The 1971 income from sale of exhibit space amounted to \$13,975.00 and the expense of the meeting was \$25,396.96. The net loss on meetings for 1966 was \$1,216.89 and 1971 meeting \$11,394.96.

The sale of exhibit space for the 1972 meeting, as of September 15, amounts to \$17,650.00 and no doubt the expenses will greatly exceed this amount of income, making it necessary for us to make up the deficit from the General Fund. The expenses for meetings of the Board; District Conferences; lecturers; and the activities of the commissions and committees have all shown an increase in cost.

(7) **PUBLICATION COSTS.** Our contract printer's labor costs have increased and so have the cost of paper and other items in connections with the publication of *The Journal* of the Indiana State Medical Association. The major cost of publishing *The Journal* has been borne by the advertisers. However, the Federal restrictions on drug advertising have resulted in decreased revenue and more cost to our members. By the use of severe economy and reduction in the size of *The Journal* and change in the quality of paper, we are hopeful that the expenditure on *The Journal* for the coming year will be an approximate level with that of the 1971-72 fiscal year.

(8) **STATIC TYPE INCOME.** A static type of income is a real problem in the financing of the association. This is due to the fact that the number of paid members has increased very slowly over the several years. An increasing number of members are exempt from payment of dues because of retirement, exemption or hardship. The very slight gain in paid membership has not been sufficient to offset the inflationary economy in which we now live.

Your Board of Trustees Finance Committee has given this matter long and thoughtful consideration and has voted to recommend the increase, a modest increase in dues, to the House of Delegates for the coming year. As we view our neighbors, we find that Michigan now has an annual dues of \$135, Illinois \$130, Kentucky \$130, Ohio \$65, Indiana \$100 and Wisconsin \$155.

What service and benefits do you get

from your ISMA dues? Since its organization in 1849 the Indiana State Medical Association has gradually increased its services and benefits to physicians of this state and has accepted more and more responsibility as protector of the public health. Here are highlights of the services your association provides:

(1) **PROVIDES A WAY** for the members of the medical profession to unite and act on matters affecting the public health and the practice of medicine.

(2) **SERVES AS A CLEARING HOUSE** of important information for members of the medical profession.

(3) **CONDUCTS AN ACTIVE PUBLIC RELATIONS PROGRAM** by providing speakers for lay gatherings, by distributing specially prepared literature to the public, by furnishing articles and editorial suggestions to the news media, by cooperating with radio and television stations on medical and health programs, and by supplying professional advice and guidance to official and voluntary agencies and organizations participating in medical and health activities.

(4) **REPRESENTS THE MEDICAL PROFESSION** through selected spokesmen before the Indiana General Assembly and the United States Congress; presents to the legislative and executive branches of the state and national governments the views and opinions of the medical profession on health and medical questions. Keeps the physicians in Indiana informed on developments and actions pertaining to legislation or administrative rulings.

(5) **KEEPS IN TOUCH STATE AND NATIONAL AGENCIES** administering medical health welfare programs in order to offer them advice and cooperation; to present views of the medical profession on administrative policies and details; to adjust differences and misunderstandings, and to provide information to physicians on the operation of these programs.

(6) **PUBLISHES THE JOURNAL** of the Indiana State Medical Association, the first line of communication among physicians of Indiana and between the Indiana State Medical Association and its members. Issued monthly, *The Journal* contains clinical and scientific articles with priority given to Indiana authors. Byline and other special articles discuss topics of timely interest to physicians. The professional activities section brings news of organization matters, ISMA policy, news on health and medically related legislation, continuing medical education programs, news of other profes-



sional organizations and additional items of interest to physicians. In addition, *The Journal* publishes a Roster and Yearbook issue in June which contains a wealth of information that is assembled nowhere else. The Roster of Members lists physicians both alphabetically and by county societies, giving addresses and specialties. The cost of *The Journal* is covered by membership dues and by advertising by ethical pharmaceutical houses and other suppliers.

(7) **ISSUES THE NEWS FLASH**, a special personalized bulletin, periodically as the occasion warrants, to all members to keep them informed on current developments and events of interest to the profession.

(8) **ISSUES LEGISLATIVE BULLETINS** to county medical society officers, legislative chairmen, and to the officers of the association when the Indiana General Assembly is in session.

(9) **PRESENTS POSTGRADUATE TRAINING PROGRAMS** available to all members by means of the annual meeting; cooperates with the Indiana Medical School and health agencies in similar projects.

(10) **ASSISTS THE STATE BOARD** of Medical Registration and Examination on matters involving the administration and enforcement of the Indiana Medical Practice Act.

(11) **THE BOARD SUPPORTS AND ASSISTS** Indiana University School of Medicine and hospitals in maintaining a high standard of training for students, interns and residents.

(12) **COOPERATES WITH THE AMERICAN MEDICAL ASSOCIATION** in promoting activities in providing services of value to the medical profession.

(13) **MAINTAINS AN EXECUTIVE OFFICE** and building in Indianapolis, manned by a staff which devotes its full time to the interests of the medical profession is furthering the activities of the association under the direction of the Board of Trustees, the Executive Committee, the various Commissions and Committees and officers and in promoting programs and projects for the health of the people of the state of Indiana.

(14) **CONDUCTS AND SPONSORS** district and statewide conferences on specific subjects of interest to physicians, such as the district meetings.

(15) **MAINTAINS A SPEAKERS BUREAU** to help county medical societies and other professional groups, lay audiences, etc.

(16) **MAINTAINS LIAISON WITH INDIANA HOSPITALS** and with the

Indiana Hospital Association, as well as other professional organizations.

(17) **FURNISHES MEMBERS WITH INFORMATION** about candidates for public office regarding their views on medical and health matters.

(18) **PROVIDES ALL INDIANA DAILY AND WEEKLY NEWSPAPERS** with a weekly column on health.

(19) **MAINTAINS A PHYSICIANS' PLACEMENT SERVICE**—a service to both physicians and to communities.

**THIS IS WHAT YOUR ASSOCIATION DOES FOR YOU PERSONALLY.**

In order to become eligible and remain eligible for coverage under all ISMA-sponsored insurance plans, you must be a member of the Indiana State Medical Association.

(1) **GROUP TERM LIFE INSURANCE.** Sponsors a group term life insurance program providing up to \$40,000 coverage plus many other features, including accidental death, dismemberment, dependent coverage, waiver of premium and many others.

(2) **GROUP ORDINARY LIFE INSURANCE.** Sponsors a group ordinary life insurance program providing up to \$40,000 coverage plus many other features including accidental death, dismemberment and waiver of premium.

(3) **CORPORATE EMPLOYER'S LIFE INSURANCE.** Sponsors a plan specifically designed to suit the needs of members who carry on their practice as active, full-time employees of professional corporations in which they have ownership interest. Significant features include tax advantages, selection of coverage schedules, easy participation requirements, ancillary benefits, dividends, and many others.

(4) **OVERHEAD EXPENSE INSURANCE.** Sponsors a plan to provide for payment of your overhead expense during illness which is on an 18 or 36-month basis, from \$50 per month up to \$2,500 per month maximum.

(5) **AUTOMOBILE LEASE PROGRAM.** The Association offers its members an automobile lease plan under which the member selects the make and model of automobile, the specific equipment and optionals, and leases the vehicle for 24 months. Special lease programs are also available on a short-term basis.

(6) **RECREATIONAL VEHICLE LEASE PROGRAM.** Members may participate in a motor home leasing program whereby these vehicles can be leased for vacation periods or weekends.

(7) **TRAVEL EDUCATION PRO-**

**GRAMS.** Enables physicians to obtain educational program, hotel, meals and travel throughout the world at cost below regular airline fares.

(8) **NARCOTICS.** Information and advice on matters relating to the handling and administration and prescribing of narcotics, narcotic licenses, interpretation of narcotic regulations, etc., will be supplied after consultation with proper Federal and state officials.

(9) **REFERENCE MATERIAL.** If you need accurate, up-to-date data for a talk or paper before a lay organization, the executive office will assist you. It has reference material on many subjects pertaining to public health, medical economics, legislation, etc. It is not equipped to provide material for scientific talks. This, however, can be obtained from medical libraries, current medical publications, or from the library of the American Medical Association at 535 North Dearborn Street, Chicago.

(10) **DATA ON PHYSICIANS.** An alphabetical file of Indiana physicians, with biographical data on most of them, is maintained at the Indianapolis office. Also, that office has the latest available information on which Indiana physicians are certified by specialty boards. Moreover it has the means of obtaining information as to specialists and consultants practicing in other states. This information is made available on request.

(11) **HOSPITAL DATA.** Information regarding Indiana hospitals and extended care facilities in nursing homes is available upon request. Also material is available on hospital construction, medical staff organization and accreditation requirements.

(12) **PLACEMENT SERVICE.** Physicians seeking locations or physicians in practice looking for an assistant or an associate will find the information maintained in the Indianapolis office helpful. This includes a list of areas needing physicians, hospital and public health facilities in such areas, data on economic and social conditions at various parts of the state, school facilities, churches, etc.

(13) **WORKMAN'S COMPENSATION.** Through its executive staff the association will investigate the status of claims in which you may be interested, assist in the elimination of delays in payment of your fees, represent you in regard to Bureau payments of your claims, endeavor to straighten out misunderstandings and differences between you and the Bureau of Workman's Compensation. In requesting this service you should cite the number of the workman's compensation claims. You should be able to get this from the employer. If



you can't get the number of the claim, in requesting this service be sure to submit name of claimant, name of employer, date of injury, and date when you rendered the initial service to the claimant.

(14) **GOVERNMENT MEDICAL CARE PROGRAMS.** The Association will represent you on matters pertaining to questions which may arise under Medicare, Medicaid, CHAMPUS, crippled children, V.A. and similar programs. Difficulties which you may encounter in any of these programs will be discussed with the proper officials, if you request this service. If you desire information about any of the government-sponsored health care plans, write to the Indianapolis office.

(15) **LEGAL.** Although the Association does not provide legal services to individual members, except in malpractice cases, it will supply members with information on provisions of various laws, regulations, court decisions and legal opinions on medical and health subjects.

(16) **THE DEFENSE OF MALPRACTICE SUITS.** The Association has a plan which will reimburse the physician for employment of an attorney of his choice in malpractice cases.

(17) **TAXATION.** Information and advice will be given on taxation matters following consultation with competent state and Federal tax authorities.

(18) **HEALTH EDUCATION MATERIAL.** Information pamphlets, leaflets, and other public relations material for your waiting room and other uses will be made available upon your request.

(19) **ADVICE ON DRUGS AND SUPPLIES.** By writing to the Indianapolis office you will be able to obtain authentic information regarding acceptable pharmaceuticals, nutrition, instruments and supplies.

(20) **DRUG ABUSE.** Information for physicians on drug abuse is available from the Indianapolis office. This information includes sample speeches and background material.

(21) **FAKES AND QUACKS.** Material on many patent medicines, fakes, quacks, and imposters can be obtained from the Indianapolis office. Queries on such matters are encouraged.

(22) **INSURANCE.** The Indianapolis staff can obtain from the State Insurance Commissioner accurate information regarding insurance companies of all classifications. We will be glad to check for you.

(23) **LEGISLATION AND CANDIDATES.** Information on what the Indiana General Assembly and U. S. Con-

gress have done and are doing is published in *The Journal* from time to time, as well as special reports to the county societies. Special inquiries regarding legislative proposals and records of candidates for public office will be answered by the Indianapolis office. The best way to get data on candidates is from your county society legislative committee.

(24) **BUILDING REGULATIONS.** When constructing or remodeling your office, you must comply with certain state regulations pertaining to public buildings, plumbing, etc. You can get this information from the Indianapolis office. Advice should be sought locally because of local regulations.

(25) **VITAL STATISTICS.** Statistics on birth, death, communicable diseases and related matters may be obtained by writing to the Indianapolis office which has close liaison with the Division of Vital Statistics of the Indiana State Board of Health.

(26) **INSTITUTIONS.** The Indianapolis office is prepared to offer suggestions regarding institutions offering services for the care of mentally ill, those with chronic diseases, mentally retarded children, alcoholics, narcotic addicts, etc.

(27) **SPEAKERS AND MOVIES.** You may be asked to address a civic organization or to provide a speaker for such a meeting or PTA meeting, luncheon, club affair, etc. Many of these groups want a medical health movie. The Indianapolis office can help you. They can supply you with data for your talk, tell you where to get the movies, and help you to obtain exhibits—free.

(28) **SCIENTIFIC MATERIAL.** Those needing scientific materials can get them from the library of the American Medical Association in Chicago. The Indianapolis office will make the request for you.

(29) **PROFESSIONAL RELATIONS.** When confronted with a problem in ethics or professional relations, submit it for study by the appropriate commission of the association which can give informed opinions and advice.

(30) **TOLL FREE TELEPHONE SERVICE** 24 hours per day.

The structure of the Indiana State Medical Association includes more than seven committees and thirteen commissions on which over 250 physicians serve, representing a cross section of the profession as to geographical location and specialty. These commissions and committees advise the Board of Trustees and the House of Delegates on clinical, scientific, socioeconomic and organizational matters.

Your Board Committee on Finance therefore urgently requests the House of Delegates to adopt the following resolution:

WHEREAS, the Indiana State Medical Association has been forced to reduce some of its activities in order to operate on a break-even point; and

WHEREAS, income from advertising in *The Journal*, as well as exhibit space at the annual meeting, has been decreasing over the past several years; and

WHEREAS, the Association is being asked by the House of Delegates and by the various commissions and committees and by the exigencies of the times to undertake more activities and to expand the existing activities; and

WHEREAS, the Indiana legislature is going from a biennial to an annual session, making additional staff necessary;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association dues be increased \$10 from \$100 to \$110 per year effective January 1, 1973.

GILBERT M. WILHELMUS, M.D.,  
*Chairman*

LOWELL J. HILLIS, M.D.

LESTER H. HOYT, M.D.

ELI GOODMAN, M.D.

JOSEPH FERRARA, M.D.

JAMES HARSHMAN, M.D.

MARTIN O'NEILL, M.D.

## Medicine and Religion

### HOUSE ACTION: Ordered filed.

How big should a program be?

Just what projects a committee on medicine and religion can become involved in was outlined at the AMA Annual Medicine and Religion Workshops. One of our Committee members attended in January. An effort has been made to send a different member of the Indiana Committee each year to the national meeting to give added insight to all the members.

This year's conference indicated some 30 projects in which state and local committees could become involved. After reviewing these projects it was felt that another project such as, say, conference-type presentation on abortion, would probably intrude on a busy schedule. Many doctors, our Committee has found, are involved already in local medicine and religion projects. Nationwide it is found, medicine and religion projects are either local city or county efforts, or a statewide effort held in one locale from time to time. If a good project lending itself to the latter type of statewide inter-



est becomes available, the State Committee will promote or help execute it.

Your State Committee in the meantime has been available to receive and disseminate reports of a religious and medical nature and to encourage local projects. We would like to receive items of new activities in local areas that interested doctors over the state would like to hear about. Please write to the chairman about projects you know are or have been in progress.

B. E. KINTNER, M.D., *Chairman*  
JOHN C. SLAUGHTER, M.D.  
EDWIN B. BAILEY, M.D.  
HUNTER SOPER, M.D.  
NORMAN FOGLE (SAMA)

## Sports and Medicine

No report was submitted.

**HOUSE ACTION:** Recommendation in view of the number of injuries incurred in sports in the state that this committee become more active. Approved.

# Reports of Commissions

## Convention Arrangements:

**HOUSE ACTION:** The scientific program and exhibits constitute the report of this commission. Efforts of commission members are commended. Filed.

## Constitution and Bylaws.

The Commission on Constitution and Bylaws had several matters under discussion for consideration by this House of Delegates and we make the following recommendations for changes in the Constitution and Bylaws:

**HOUSE ACTION:** The following amendments to the Constitution were introduced and approved but will lay over until the 1973 meeting before final action is taken.

## Constitution

Constitutional changes: These are being presented at this meeting for the first time and, as required in the Constitution and Bylaws, the proposed amendments shall lay over for one year for final action to be taken in the annual meeting in 1973.

Article IV, Section 3, Composition of the Association

Be It Resolved that Article IV, Section 3, be amended by inserting a period after the word "Association" and striking the balance of that sentence. Section 3 will

then read:

Sec. 3. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

Article IV, Section 5, Composition of the Association

Be It Resolved that Section 5 of Article IV of the Constitution be amended by striking the entire Section 5 as now printed and substituting the following:

Sec. 5. Senior Members. Senior members shall be physicians of the State of Indiana who have attained the age of 70 years and have held membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by their county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other such state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

A recommendation has been made that the immediate past president of the Association be made a member of the Board of Trustees with the power to vote. Therefore, your Commission recommends the following:

Be It Resolved that Article VI be amended by adding the words "immediate past President" following the word "Treasurer." Article VI would then read as follows:

The Board of Trustees shall consist of (1) the trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) *ex officio*, the president, president-elect, treasurer, immediate past president with power to vote and assistant treasurer without power to vote except in case the treasurer be absent. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions

of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. A majority of elected trustees shall constitute a quorum.

Article IX, Section 1, Officers

In line with the above-proposed amendment, it would also be necessary to amend Article IX, Section 1, of the Constitution, by inserting after the word "President-elect" and before the word "an" the words "immediate past President." Article IX, Section 1, would then read as follows:

Section 1. The officers of this Association shall be a president, a president-elect, immediate past president, an executive secretary, a treasurer, an assistant treasurer and the trustees, each of whom shall be a member, except the executive secretary, who need not necessarily be either a physician or a member.

Article V — House of Delegates

In an effort to further solidify the specialty and Section groups of our State, your Commission recommends the following:

Be It Resolved that Article V of the Constitution be amended by striking the word "and" between the word "alternates" and "(3)", by removing the period after the word "Association" replacing it with a comma and adding "and (4) delegate or their designated alternate delegate elected by their respective Section." Article V of the Constitution will then read:

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates, or their designated alternates, elected by the component county societies; (2) the trustees, or their designated alternates, (3) the ex-presidents of the Indiana State Medical Association, and (4) delegate or their designated alternate delegate elected by their respective Section. The following shall be *ex officio* members: the president, the president-elect, the executive secretary, the treasurer and assistant treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

## Proposed Constitutional Amendment

The chairman of the Committee on



Rules and Order of Business stated that the committee had reviewed a request for a proposed constitutional amendment from the chairman of the Commission on Medical Education and Licensure for a Distinguished Member category to be included in the Constitution and Bylaws. A motion was duly made, seconded and carried that this proposal be laid on the table so that it can properly be voted on at the 1973 meeting of the House. Proposed amendment which is as follows will be referred to the Commission on Constitution and Bylaws if wording is to be changed.

Under ARTICLE IV.—COMPOSITION OF THE ASSOCIATION a new Sec. 3 to be added to read as follows:  
Sec. 3—Distinguished Members. Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of a minimum of 150 hours for three years of continuing medical education shall be designated as Distinguished Members.  
The previous Section 3 will then become Section 4 and the rest of the sections through Section 8 will be renumbered in sequence.

Bylaws

**HOUSE ACTION:** The following amendments to the bylaws were adopted and will become effective immediately.

Bylaws

Chapter III, Section 1, Sections  
Be It Resolved that in order to carry out a recommendation, your Commission proposes that Chapter III, Section 1, of the Bylaws be amended by the addition of:  
o. Interns and Residents  
This would have the effect of creating a Section for Interns and Residents and would change the present sentence "o" to sentence "p."  
Chapter IV, Section 7, House of Delegates  
In order to more effectively carry out the actions of the procedure of the House of Delegates, your Commission recommends that an amendment be made to Chapter IV, Section 7, by inserting another paragraph at the end of the present Section 7 which will provide for the composition of the Committee on Rules and Order of Business to be made up of the chairmen of the various reference committees.  
Be It Resolved that Chapter IV, Section 7, of the Bylaws be amended by the addition of a final paragraph which reads as follows:

The Committee on Rules and Order of Business, mentioned above, shall be composed of the chairmen of the various reference committees appointed by the president.  
Chapter XIII, Section 1, The Medical-Legal Review Committee  
Be It Resolved that Chapter XIII, Section 1, be amended by removing the period at the end of the paragraph, inserting a comma, and adding the words "in all other medical-legal matters." Chapter XIII, Section 1, will then read as follows:  
Section 1. The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in the Code in the form in effect from time to time as approved by the Association, in all other medical-legal matters.  
AMA Bylaws, Chapter III, Section 1, Dues  
**HOUSE ACTION:** Not Adopted.  
Your Commission, following a discussion of the senior membership status, would like to recommend to the House of Delegates for their approval a proposed resolution to be introduced by the Indiana Delegation to the American Medical Association's House of Delegates' meeting in November, 1972, as follows:  
Be It Resolved that Chapter III, Section 1, of the Bylaws of the American Medical Association be amended in Paragraph (e) by striking "70th birthday" and inserting "65th birthday," which would then read:  
(e) A member, on request, regardless of local dues exemptions, on January 1 following his 65th birthday.  
GORDON S. FESSLER, M.D.,  
Chairman  
BERNARD B. ROSENBLATT, M.D.  
PAUL B. ARBOGAST, M.D.  
ELI GOODMAN, M.D.  
GLEN WARD LEE, M.D.  
JOHN M. RECORDS, M.D.  
WALLACE A. SCEA, M.D.  
WILLIAM J. MILLER, M.D.  
GILBERT H. WHITE, JR., M.D.

EVRETT SMITH, M.D.  
WILLIAM B. HUGHES, M.D.  
CHARLES PLANK, M.D.  
MALCOLM WREGE, M.D.  
LESTER RENBARGER, M.D.

Legislation

**HOUSE ACTION:** Ordered filed.

The commission on Legislation, under the chairmanship of Donald E. Wood, M.D., had its first experience of participating in the new interim meeting of the Indiana State Legislature when the 30-day session for even-numbered years and the Indiana Legislative Council were established.  
Hearings on bills to be acted upon in the '72 session were assigned to committee early in November and hearings were held on a great number of bills which were prefiled and were available for immediate floor action upon the convening of the legislature on January 11, 1972.  
At the first meeting of the Commission they discussed various bills. The Commission reviewed 21 bills in the Senate and 10 in the House. One of the bills that the ISMA Commission was interested in backing was one which created a method of certification and control of the physician assistant, which is fast becoming a reality in the practice of medicine. Due to pressure brought by some groups opposing this bill, the Commission had a meeting with the Executive Committee of the Association, the Indiana Nurses Association, the Indiana Pharmaceutical Association, and the Indiana Optometric Association. The meeting was for the purpose of attempting to resolve the opposition of these groups to the bill and to explain why the Association felt it necessary to have such a bill adopted by the legislature. In spite of this effort, the bill was lost and not adopted. There is no doubt that the creation of the medical assistant school by IU-PUI on the Fort Wayne campus will add still more reason for such a bill to be introduced in the '73 session.  
In an effort to gain local understanding and support of the county medical societies, copies of several bills with an explanation were distributed and local physicians were encouraged to contact their representatives in the State Legislature.  
The Commission also met with representatives of the State Department of Welfare and the Board of Medical Registration and Examination for a discussion of materials relating to these organizations.



All in all, during the course of the 30-day session the Commission wound up reviewing a total of 30 House bills and 26 Senate bills. Under the new arrangement there is no doubt that the Commission on Legislation will also be involved in the 12-months' activity as it prepares for the annual session of the State Legislature as well as reviewing materials to come before Congress.

Attendance at the meeting of the Commission was good and I, as chairman, wish to express my thanks for the cooperation of the members of our commission as well as the legislative representatives in the various county medical societies.

DONALD E. WOOD, M.D.,  
Chairman

ROBERT E. ARENDELL, M.D.

ROBERT ROSE, M.D.

NELSON WOLFE, M.D.

LESLIE M. BAKER, M.D.

WILLIAM BANNON, M.D.

JOHN A. DAVIS, M.D.

JOHN PANTZER, M.D.

JACK L. ALEXANDER, M.D.

MAX N. HOFFMAN, M.D.

A. P. BONAVENTURA, M.D.

RICHARD L. GLENDENING, M.D.

DEWAYNE HULL, M.D.

HARRY STOLLER, M.D.

JAMES KIRTLEY, M.D.

DONALD TAYLOR, M.D.

JOSEPH BLACK, M.D.

JOSEPH McPIKE, M.D.

FRED POEHLER, M.D.

HARVEY SACKS (SAMA)

## Public Information

### HOUSE ACTION: Ordered filed.

The Commission on Public Information met on four occasions during the calendar year 1972 to conduct routine business and to discuss special matters of importance to the Indiana State Medical Association.

*Awards Program.* Applications for newspaper, radio, and/or television awards which are presented annually by ISMA were screened, and a recipient was selected in each category by the Commission. Applications for the Physician's Community Service Award were also screened by the Commission and an award was made to be presented at the annual ISMA Convention.

*Waiting Room Display Kits.* The program for the dissemination of these kits was developed this year. After much work by this Commission on this program, the Board of Trustees of ISMA

gave their approval to this program and a pilot project consisting of 1,000 of these kits will be distributed to fellow physicians of ISMA. This program will be budgeted in the 1973 fiscal year and will be underway at the beginning of next year. It will be a continuing project of the commission.

*Physician Liability Booklet.* This booklet was developed by the Commission and patterned after one prepared by the Illinois Medical Association. The Board of Trustees of ISMA appropriated monies for this project in 1972, and this booklet will be ready for distribution to every physician in the state of Indiana in 1973.

*Physician Activity File.* A new project which was discussed and which will be promoted by the Commission is the updating and developing a computer-compatible physician activity file for use by the officers and staff of ISMA. Data on each physician member of ISMA is the goal of this project. Data thus secured could then be used by the officers and staff of ISMA to better use the many and varied talents of physicians throughout the State Medical Association.

There are no recommendations from this Commission to the House of Delegates of ISMA.

The Commission would like to publicly thank the officers and members of the staff of ISMA for their suggestions and help.

FRED DAHLING, M.D.,  
Chairman

WILLIAM B. CHALLMAN, M.D.

THOMAS O. MIDDLETON, M.D.

LOUIS H. BLESSINGER, M.D.

KENNETH D. SCHNEIDER, M.D.

RICHARD S. BLOOMER, M.D.

ROBERT W. HARGER, M.D.

PAUL BURNS, M.D.

BARBARA BACKER, M.D.

HARRY G. BECKER, M.D. (At Large)

VICTOR JOHNSON, M.D. (At Large)

## Governmental Medical Services

**HOUSE ACTION: Ordered filed. Referred to Board of Trustees for consideration of forming a commission or committee for the purpose of reviewing third party payments as well as claims questioned by third parties.**

During the course of the last 12 months the Commission has met on numerous occasions, both in the body and by telephone conference calls.

The usual review of CHAMPUS claims has been accomplished with only infrequent dissatisfaction with decisions.

The Federal fiscal authority in Denver has commended the Indiana program, both for its efficiency and for the apparent satisfaction by the consumer and, in most cases, the provider of care.

Some attempt had been made in the past two years to develop an Insurance Review Committee because of the numerous third party decisions questioned by physicians. This is not completely successful. However, this Commission has been referred numerous insurance as well as Medicaid claims to adjudicate. This has been accomplished following the same format as the CHAMPUS. An average of three to ten claims per month has been reviewed.

The review of insurance claims becomes more complicated because of the multiplicity of physicians and procedures claimed by any one patient. Another problem that has become apparent is the so-called "usual and customary" allowances agreed upon by the insurance company. This varies between different insurance companies and also different physicians in areas of the State. In this area, we have attempted to set some guidelines that will be satisfactory to all. Since the House of Delegates, as yet, has not agreed upon the use of the Relative Value Schedule in the State, we have been somewhat hampered in developing a concept of what is "usual and customary."

It would be the recommendation of this Commission that the Indiana State Medical Society consider forming a commission or committee for the purposes of reviewing third party payments as well as claims questioned by third parties.

In this instance, a source of referral such as a Relative Value Schedule or some such form would be most helpful.

Most of the remaining portions of the meetings were taken up with the review of the Medicaid program, both from the physician's standpoint and also that of the Welfare Department.

There are now 210,000 people eligible for medical care in the state of Indiana. Care is being provided at approximately \$40 per person per month, which is approximately eight per cent higher than in 1968. At that time there were only 68,000 people on welfare.

The total Medicaid budget for 1971 was in excess of \$100 million. The physicians received approximately 10.4% of this in fees.

Some attempt was being made by the Welfare Department to reduce the number of eligibles. However, this has been complicated by the active rights organization and numerous court suits that are



in progress.

A minimum income of \$6,500 is being asked for by the rights organizations; however, the Welfare Department is against it, for it would represent a usual income in excess of \$10,000. Anyone even receiving a small service or assistance from Welfare Department becomes eligible for Medicaid, which is a high cost item to the Welfare Department.

The Welfare Department is satisfied with the administration and fiscal arrangement of Medicaid by Blue Shield and also quite pleased with the cooperation of the state medical society in the care of their indigent. There has been every effort made by the Welfare Department to upgrade physicians' fees within the limits of Federal regulations.

At the present rate of expenditure for 1972, it would seem that the Medicaid budget will be in excess of \$120 million, an increase of 20% over 1971.

The total Federal Welfare budget is in excess of \$23 billion according to HEW in June 1972. This, of course, includes all services.

Information and review regarding the foundation concept for care of the indigent as well as utilization of a CHAPS or pre-admission review has been considered. No definite recommendations can be made at this time for all available information.

The State of Illinois has instituted a review program only in an attempt in the future to possibly use the foundation concept for complete medical care of the indigent. This will have to be watched closely as it is a popular form of providing care. More information will be available on this topic in the future and will be provided to the membership.

I would like to take this opportunity to thank all the members of the Commission for their cooperation and active interest over the past two years. It has been indeed most gratifying for me to be chairman of this Commission and I wish to thank the members of the Executive Staff of ISMA for all their assistance, recommendations and encouragement during my tenure.

MICHAEL J. MASTRANGELO, M.D.  
Chairman

COLA K. NEWSOME, M.D.

FRANCIS H. GOOTEE, M.D.

FRANK BARD, M.D.

RENATE G. JUSTIN, M.D.

TOM S. SHIELDS, M.D.

J. E. HOLMAN, Jr., M.D.

GEORGE E. BRANAM, M.D.

RAMON B. DUBOIS, M.D.

LEE L. TRACHTENBERG, M.D.

GEORGE A. TEABOLDT, Jr., M.D.

PAGE E. SPRAY, M.D.

CHARLES R. ALVEY, M.D.

(At Large)

GLEN V. RYAN, M.D. (At Large)

## Public Health

**HOUSE ACTION: Ordered filed. Recommendation of Reference Committee that the Section on Drugs include all drugs in its next report and not just marijuana and the Commission clarify its position on smallpox vaccination in its next report.**

**Recommendation that Public Health Commission do a state survey on Resolution 71-5, STATEWIDE MORATORIUM ON AMPHETAMINE DRUGS, to see if it has been implemented.**

The Indiana State Medical Association Commission on Public Health had four meetings in the 1971-72 year—November, January, March and May. The Commission, consisting of 16 members, had an average attendance of seven. The faithful loyalty of several members to the needs of the Association is greatly appreciated. Dr. Edgar Cantwell served as secretary; Dr. A. C. Offutt was vice chairman and did much work on: (1) the Commission's report to the National Commission on Marijuana and Drug Abuse, (2) the plan for reorganization of the local health department, and (3) a statement on smallpox immunization. Dr. Warren Niccum provided a good background program on drug abuse and attended a meeting on drug abuse in Arizona for us. Drs. James Hawk, Hubert Goodman and Arnold Brockmole contributed regularly. We were also pleased to have Tim Byers, a member of the Student AMA, with us.

The main work of the Commission was in three fields: (1) drugs, (2) venereal disease, and (3) a plan for regional health departments.

We had a report from Dr. Niccum on his attendance at the AMA's Annual Conference of State Mental Health representatives and heard direct testimony from a drug user. We composed a letter, had it approved by the Board of Trustees, and sent it to Raymond P. Shafer, Chairman of the National Commission on Marijuana and Drug Abuse. This was in reply to a request from the National Commission. The letter said, in

essence, that our knowledge of marijuana is fragmentary and will require continued study with respect to: (1) effects of the drug by itself, (2) effects when combined with other drugs, (3) effects on judgment and motor skills, (4) physiological effects, (5) psychological effects, (6) social effects, (7) economic effects, (8) chemical composition, (9) active ingredients, (10) short and long-term effects, and (11) statutory regulations. The letter stressed that there should be an emphasis on the education of our citizens about marijuana.

On the subject of venereal disease, the consensus of the Commission was that the doctors of Indiana needed to have the subject brought before them frequently and from many directions. Dr. Arnold Brockmole agreed to write an article on venereal disease to be published in *The Journal* of the Indiana State Medical Association.

Finally, the main efforts of the Commission were directed to producing a plan for regionalization of the state's health departments. This action was prompted by the fact that many of the local health departments in the state are inadequate for the important work they are meant to do. The beginning of this effort was a year ago and it came to fruition in a document entitled, "The Regional Health Department—Meeting Modern Demands." This was created and adopted by the Commission and sent to the Board of Trustees of the Indiana State Medical Association with a recommendation for adoption. The Chairman of the Commission, along with Dr. A. C. Offutt, appeared before the trustees of the Indiana State Medical Association at their June meeting to present the proposal. It was accepted for further study and a committee appointed for this purpose. The Commission would hope that this document might be either approved as is, or approved in a form modified, as might be necessary, to be used as a basis for legislation in the near future.

The main provisions of the document are that the state may be divided into fourteen regions, similar to those being used for the hospital and mental health facilities construction program, and each of these regions then would have a health department with the best available qualified personnel and a comprehensive program. Smaller units, such as counties, would continue to have more limited services backed up by the more complete department close by in the region. Economically the state's tax structure cannot support a first-class



Board of Health in each county but could support fourteen good regional departments.

Two possible methods of financing are mentioned: (1) funds accrued by uniform regional tax rates would be paid into a special account at the regional level. They would be spent by the regional Board of Health with budgetary review conducted by representatives from the fiscal agencies of each of the participating civil divisions. (2) Tax funds collected as above could be paid into a special dedicated state fund for public health managed by the State Board of Health. The Regional Fiscal Management Group would not be necessary because the state Board of Health would perform this function. Funds from the regions would be pooled and all allocated on the basis of the formula developed by the State Board of Health.

In conclusion, it would appear that we would be getting much improved public health services at possibly no increase in the cost to the individual taxpayer.

The above brief description is much too general, of course. For the additional information of the House of Delegates, we are concluding this report with an abstract of the more detailed document. Even the original document is really just a starting point in the process of improving public health in Indiana. Copies of the document have been made and, I'm sure, would be available at the Indiana State Medical Association to those interested. The Commission wishes to urge those who are concerned to contribute to the plan by contacting the Commission.

## REGIONAL HEALTH DEPARTMENTS—

### MEETING MODERN DEMANDS ABSTRACT OF POSITION PAPER

#### *Introduction*

Currently in public health, as in other areas, recognition is given to the restrictions placed upon broad programs by limiting them to civil boundaries. Authoritative studies have indicated that Indiana may be divided into fourteen (14) regions which are being used both in the hospital and the mental health facilities construction programs. The proposal in this paper will be that such regionalization be considered with respect to the establishment of jurisdictions for local health departments.

#### *The Problem*

The growth of responsibility has re-

flected the demand of the public for more and sophisticated services. This has resulted in an increase in the duties discharged by local health departments. As a result of the interaction of these two factors, if the local health departments are to meet the demands of the population within their jurisdiction, they must do so by achieving more adequate funding.

#### *The Local Health Department*

In order to properly staff and fund local health departments, the cost per capita must be extended over a larger population group. To do this, civic pride in the local health department in each small unit of civil government must be surrendered in favor of a greater good. The jurisdiction of the local health department must, therefore, be extended through the development and operation of official programs on a regional basis.

#### *External Influences*

The restricted jurisdiction of existing local health departments apparently does not offer a challenge and recompense which will attract personnel. Activities and services which are properly within the purview of the official local health agency frequently are operated as a function of a voluntary group or as a part of a program in which the health aspect is but a secondary thrust. Regionalization will continue to perpetuate local control of the local official agency in dealing with local problems. The proposed broader jurisdiction will tend to produce a more challenging and varied group of problems and compensation thus helpful in attracting adequate staff.

#### *Fiscal Impact*

It is recognized that regionalization will cause certain inherent problems to surface. One of these is because the rural and urban components of the area may generate fears that only the voice of the city will be heard. Careful organization, operation, and education can dispel this fear.

Funds which are accrued by a uniform regional tax rate would be paid into a special account. Such monies would be expended by the board of health with a budgetary review conducted by representatives from the fiscal agencies of each of the participating civil divisions. Certain restrictions would be applied and an annual audit required.

A second method of financing, which is less palatable but is presented since it

represents a philosophy to which some subscribe, is presented. Tax funds collected, as noted above, could be paid into a special dedicated state fund for public health which would be managed by the State Board of Health. The region would not need a fiscal management group since this function could be carried on in the fiscal operation of the State Board of Health. If this arrangement were to be adopted, distribution to the regions would then be based on a formula developed by the State Board of Health. In such a case, funds from all regions would be pooled and allocated in accordance with the formula.

#### *Regionalization*

Regionalization is not proposed as a method for providing the same service at a lesser cost. The actual proposal involves the more efficient use of personnel, the providing of more of the services which are being required, the transfer of certain operative functions from the state to local authorities, and a unification of health services in the region. It is recognized that total costs might be increased; but the increase would not be in proportion to the additional services, both in quantity and quality, which could be provided under a regional organization. The per capita cost of providing official health services would be thus spread over a larger population; and, as a result, cost to the individual could conceivably be lessened.

JAMES JOHNSON, M.D.,  
Chairman  
ARNOLD BROCKMOLE, M.D.  
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WILLIAM K. NEWCOMB, M.D.  
WARREN NICCUM, M.D.  
JAMES S. ROBERTSON, M.D.  
ANDREW C. OFFUTT, M.D.  
(At Large)  
JAMES HAWK, M.D.  
(At Large)  
HUBERT GOODMAN, M.D.  
(At Large)  
TIMOTHY BYERS (SAMA)

## Voluntary Health Agencies

### HOUSE ACTION: Ordered filed.

As in the past, this Commission was organized with representatives from each of the 13 districts with two members at large. The members of the Commission



are: Dr. Albert Ritz of Evansville, Dr. Robert Rang of Washington, Dr. T. A. Neathamer of Jeffersonville, Dr. Harry Baxter of Seymour, Dr. Wayne Crockett of Terre Haute, Dr. Frank Deanovic of Richmond, Dr. Lowell Painter of Winchester, Dr. Theodore Person of Covington, Dr. Walfred Nelson of Gary, Dr. Wendell Ayers of Marion, Dr. Richard Willard of Bluffton, Dr. Frank McGue of Michigan City. At-large members are: Dr. A. T. Stone of Indianapolis, Dr. Charles Rushmore of Indianapolis, and a student from the Indiana University School of Medicine, representing the Student American Medical Association, Mr. Richard Schwartz.

The Commission held its organizational meeting on November 21, 1971, and reviewed the constitutional provisions required of this Commission and the operation of the last 10 years. President Dr. Petrich and President-Elect Dr. Gosman met with the Commission at this meeting, and both Mrs. Chernish, president of the Women's Auxiliary and Mrs. Smith, president-elect of the Women's Auxiliary met with the Commission.

The Commission appealed to the Auxiliary in hope that a Commission or a Committee of the Auxiliary parallel to this Commission can be set up and work with the Voluntary Health Agencies of the state. This was implemented at a later meeting.

At this first meeting, the Annual Scientific Program that had been put on in connection with the Indiana Public Health Association was discussed, and it was decided, because of the poor attendance at this activity for the past several years, it would be dropped. Efforts had been made to persuade the directors of Public Health Association to give us more of an audience, but no corrective action was taken.

*The Journal* of Indiana State Medical Association published a list of Voluntary Health Agencies in Indiana and in this list there were some agencies that are unable and unwilling to meet the criteria of this Commission for approval. The Commission asked *The Journal* to consult with this Commission before any such list is published in the future.

It was arranged that at least two doctors of the Commission were assigned in liaison to each of the state organizations with which the Commission works and the agencies were notified of such liaison assignments. It was asked that these members of the Commission be kept informed of the activities of the various agencies and be invited to their

business meetings and be invited to sit in on their policy-making Boards.

The next meeting of the Commission was held on January 15, 1972, and Dr. Nelson was elected vice-chairman and Dr. Rang was elected secretary. The Commission reviewed the liaison assignments and made reports on their contacts with various agencies to which they were assigned, and the usual review of agencies took place in which many were approved, but there were some that failed to meet the criteria of the Commission and were not approved. The reasons for failure to meet the criteria are listed in the original minutes of the Commission, but since it is a policy of this Commission not to publish those agencies failing to receive approval, they are not mentioned in this annual report. At this meeting Dr. Petrich met with the Commission and suggested that an extension of our work should be to compile a form to be sent out with the annual report form which gives the evaluation of the work of the agency. The Commission also voted to notify the Convention Arrangements Committee as to its possible ability to obtain nationally known speakers through the voluntary health agencies for the program of the Indiana State Medical Association.

On the evening of January 15 a dinner was held for the Commission and their wives or guests. This was attended by Dr. and Mrs. Petrich and the Student Representative of the Student American Medical Association, Mr. Schwartz, and his wife.

On Sunday, January 16, the Commission reconvened at the headquarters of the ISMA, and to this meeting all the Voluntary Health Agencies in the state with statewide programs were invited, whether they were approved or not in the past year. Invitations were sent to the president and chief executive officer and five volunteers from each of the agencies. A round-table meeting was held with these agencies. The Commission asked for suggestions and criticism from the agencies, the program was explained, and for the first time the proposed joint program with the Auxiliary was explained to the agencies. They met this plan with real enthusiasm and stated it would be a great help to the agencies to have the ladies participate.

Our Commission asked the voluntary health agencies representatives for any suggestions. Greater participation on the part of the members of the Indiana State Medical Association was requested by many. Some of the agencies thought that

greater publicity should be given to the work that this Commission has been doing with the voluntary health agencies. Many suggestions were offered on how it might be possible to reach greater numbers with information. The agencies also reviewed their old programs and discussed their plan for the future. The Commission was complimented on bringing in all the agencies, even though they may not be on the approved list for the previous year.

As a result of the discussion at this meeting, the chairman appointed a special committee from the voluntary health agencies and the commission to work on an evaluation questionnaire.

A general survey of the agencies present revealed approximately 400,000 lay people working as volunteers in voluntary health agencies in the state of Indiana. At noon, a box lunch was served to those present, compliments of the Indiana State Medical Association. The meeting broke up on a very optimistic note for the program of this Commission and the voluntary health agencies together in the future.

The final meeting of this Commission was held at the headquarters of the Indiana State Medical Association on May 7, 1972. At this time the report of the Special Committee to draw up an evaluation sheet to be attached to the annual questionnaire to the agencies was reviewed, slightly revised, and accepted. This evaluation sheet is to be in narrative form in answering four or five additional questions in addition to the factual information required by the criteria in the past. The general form of the criteria questionnaire was also reviewed and corrected to simplify it for the agencies next year.

At this meeting Mrs. Philip Smith, president of the Auxiliary, outlined to the Commission, the efforts of the Auxiliary in response to our request. A committee of the Auxiliary made up of representatives from each of the 13 medical districts has been set up with Mrs. Lois Walker of Yorktown as the chairman. Mrs. Smith is polling the county societies that have Auxiliaries to give us the names of the doctors' wives already working in voluntary health Agencies. Mrs. Smith is also to appoint her liaison committee with Mrs. Walker and submit these names to the Commission for assignment in liaison with the voluntary health agencies in the program of the Commission. She will then assign these ladies to these agencies and, in turn, the agencies will be informed by the Commission of the additional re-



sources of the Auxiliary available to them.

At this meeting of the Commission we were also confronted with the possible expansion of the Commission in the future with the voluntarism in health in general, which seems to be a trend of the National Council of the American Medical Association.

In view of the abandonment of the scientific program, the liaison men of the Commission have been assigned to appear before the annual meetings of the various Voluntary Health Agencies this year to present the program of the Indiana State Medical Association. This program was reviewed and, while it was not perfect, it was felt that it was worth while to consider for another year. The proposition of supplying speakers for the scientific program was also discussed and Dr. Gosman said he intended to follow this up before the meeting of the following year.

The Commission voted to distribute the placards of the names of the approved agencies again this year as in the past, with an additional distribution to approved hospitals of Indiana and to the county health boards.

The plans for the Commission for the following year were decided upon as follows:

1. Continue the program of approval for each agency as now conducted using the revised questionnaire with the addendum of a program evaluation.
2. To promote and expand the plans for the Auxiliary to appoint a committee of similar number to that of the Commission (one representative from each district) in addition to whomever the Auxiliary president wishes to appoint at large. This list of persons will serve as liaison representative to the voluntary health agencies and, upon the Auxiliary's recommendation, the Commission will then follow up by notifying the voluntary health agencies and by asking that the ladies of the Auxiliary be given responsibility and pertinent information.
3. A report form is to be provided to each liaison man for remarks concerning the agency questionnaire to be returned to the ISMA office, in case he cannot attend the Commission meeting at which the report is reviewed.
4. Plan to continue the Commission's annual January meeting with the officers and executives of the various

voluntary health agencies.

5. To publish placards and request the Editorial Board of *The Journal* of the ISMA to publish the contents of the placards at least annually to make reference to it in listing agencies of voluntary health.
6. Continue efforts to work with and get information to medical students.

Along with discussion of possible ways to reach medical students of Indiana University and the Student American Medical Association, Mr. Richard Schwartz has agreed to work out some satisfactory plan in this regard.

We reviewed the 1972 budget which shows the Commission spent \$805.63, and it was moved, seconded and passed that the Commission request the Budget Committee to allocate a budget the same as was spent for 1971-1972 with the understanding that since less was spent than was requested, the Commission would have the privilege of asking the Trustees for any additional small sum, if necessary.

As a result of the work of the Commission this year, the following voluntary health agencies having statewide programs in Indiana have been given the approval of the Indiana State Medical Association:

The American Cancer Society, Indiana Division.

The Arthritis Foundation, Indiana Chapter.

Indiana Association for Retarded Children.

Indiana Chapter of Hemophilia Foundation.

Indiana Easter Seal Society for Crippled Children & Adults.

Indiana Heart Association, Inc.

Indiana Society for the Prevention of Blindness.

Indiana Tuberculosis & Respiratory Disease Association, Inc.

Kidney Foundation of America.

Mental Health Association in Indiana.

National Multiple Sclerosis Society, Indiana Chapter.

Tri-State Epilepsy Association.

United Cerebral Palsy of Indiana, Inc.

The above list represents the largest list of voluntary health agencies ever approved in the program of the Commission.

The chairman of this Commission again wishes to thank the members of

the Commission who have worked long and diligently in the affairs of ISMA in this field. The commission as a whole wishes to thank Mr. Ken Bush for his ever-faithful work with the Commission, and without his help this Commission could not function.

NORMAN R. BOOHER, M.D.,  
Chairman

WENDELL W. AYRES, M.D.

HARRY R. BAXTER, M.D.

WAYNE CROCKETT, M.D.

FRANK DEANOVIC, M.D.

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WALFRED A. NELSON, M.D.

LOWELL W. PAINTER, M.D.

THEODORE PERSON, M.D.

ROBERT H. RANG, M.D.

ALBERT RITZ, M.D.

RICHARD WILLARD, M.D.

CHARLES RUSHMORE, M.D.

(At Large)

ALVIN T. STONE, M.D. (At Large)  
MR. RICHARD SCHWARTZ (SAMA)

## Inter-Professional Relations

### HOUSE ACTION: Ordered filed.

This commission has been relatively inactive this year. Unfortunately, too little has been done in the past and present to cultivate a good working relationship with the other allied medical professions.

My recommendation, as chairman, for the coming year is that the officers and trustees of the Indiana State Medical Association give high priority to making this commission one of our strongest commissions since the coming years will require a united front of all the allied medical professions to give leadership in our delivery of medical care.

FRED W. DIERDORF, M.D.,  
Chairman (At Large)

JACK L. SHANKLIN, M.D.

IGNACIO B. CASTRO, M.D.

GERALD BOWEN, M.D.

RICHARD L. VEACH, M.D.

MARK E. SMITH, M.D.

WILLIS W. STOGSDILL, M.D.

AMBROSE PRICE, M.D.

PAUL E. LUDWIG, M.D.

MITCHELL E. GOLDENBURG, M.D.

H. H. DUNHAM, M.D.

MARVIN PRIDDY, M.D.

RICHARD W. HOLDEMAN, M.D.

WARREN COGGESHALL, M.D.

(At Large)

GARRE BLAIR (SAMA)



# Medical Economics and Insurance

**HOUSE ACTION:** All recommendations of the Reference Committee were adopted. Items dealing with professional review and/or fee review committee and the portion dealing with Blue Shield referred to the Board of Trustees.

**Recommendation:** ISMA House of Delegates concur with action of AMA House of Delegates in June 1972 concerning independent determination of customary physicians' fee.

**Recommendation:** Portion of report dealing with the establishment of a professional review and/or fee review committee not to be adopted but made available to the Board of Trustees for their deliberation.

**Recommendation:** Approval of a form for ISMA members in the cases where insurance contracts require previous agreement of fees. Commission make available suggested forms rather than a single form.

The Commission on Medical Economics and Insurance met five times during the year. There was one joint meeting with the Commission on Governmental Services and one joint meeting with the Future Planning Committee. During one meeting the Commission on Medical Economics and Insurance met with representatives of Blue Shield and with representatives of Blue Cross to discuss current problems.

The Commission on Medical Economics and Insurance had continued reviews of the ISMA Group Insurance Programs:

- (a) *Group Disability Program.* Enrollment of new members continues at a steady rate. The program remains sound, and the loss experience has been satisfactory. It is expected that 10 percent increase in benefits added last year will be continued for another year.
- (b) *Group Life Insurance Program.* There have been no problems to date. In addition, the Group Permanent Life Plan added last year is making satisfactory progress.

In response to requests and following the recommendations of the survey made two years ago, the Commission has been endeavoring to arrange other group programs. Under study as this report is being prepared are:

- (a) *Excess Major Medical Program.* This supplemental coverage will

be available in \$15,000 and \$25,000 deductibles up to \$100,000 for members and dependents. The premiums are low and this program will be recommended to the board of Trustees for approval this fall.

- (b) *Overhead Expense Insurance Plan.* This proposed program has been reviewed; and, if minor modifications can be arranged, the Commission plans to recommend this program to the Board of Trustees for approval this fall.

We regret that no satisfactory *Group Automobile Insurance Program* has been offered, but such programs are under review. It should also be noted that no carrier has offered to write *Group Liability Insurance* on a satisfactory basis. Experience in some other states is proving less than satisfactory. In the past year the Commission on Medical Economics and Insurance and the ISMA staff have noted a marked decrease in the number of ISMA members approaching them because of problems in this area. Hopefully this is a good omen.

A large portion of the activities of the Commission, both in meetings and in individual contacts, dealt with a multitude of problems relating to third-party payment. Perhaps this is a normal evolution of the meetings between ISMA members and the Ad Hoc Committee on Blue Shield. It is obvious to the Commission that there is great concern, disenchantment and dissatisfaction expressed by many ISMA members about Blue Shield, Blue Cross, as well as other carriers. Many of the problems relate to misunderstandings and poor communications, both between carrier and physician, between carrier and patient, as well as between physician and patient, as well as to the arbitrary actions by some carriers. Pertinent to this matter is a summary of actions taken by the House of Delegates of the AMA in June 1972, which said in part:

## Fee Determinations

Delegates approved a strong resolution aimed at any independent determination of customary physicians' fees:

"Resolved, that where benefits include physicians' fees, management, labor and third party carriers shall consult with duly constituted representatives of organized medicine before determining 'usual, customary and reasonable fees,' " the measure said.

"The medical profession will not condone or tolerate action on the part of any third party that would encourage or

promulgate litigation in the settlement of any such dispute." This referred to a practice of telling a policyholder that—except where there was prior agreement between patient and physician as to the fee—the insurance company would pay the patient's legal costs if the physician sued to collect his full fee.

The resolution also reminds physicians "that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered."

The Commission on Medical Economics and Insurance recommends to the House of Delegates of the Indiana State Medical Association:

- (1) The above statement be adopted by the ISMA.
- In addition, the Commission on Medical Economics and Insurance recommends to the House of Delegates of the Indiana State Medical Association adoption of the following:
- (1) That each county medical society establish a professional Review and/or Fee Review Committee.
- (2) In the event a county medical society does not wish to establish such a committee, the district society may do so.
- (3) In the event that Nos. 1 and 2 cannot be accomplished, the House of Delegates of the ISMA empower the president of ISMA to appoint such a committee. Such a committee be empowered to arbitrate those cases in which local solution cannot be achieved.
- (4) That if a carrier elects to use such committee, they be bound by the findings of the committee.
- (5) Such a program be self-sustaining by charging a fee to the carrier for such a review.

In addition, the Commission on Medical Economics and Insurance recommends the approval of a form for the use of ISMA members in estimating charges for a procedure in the cases where insurance contracts require previous agreement of fees in order for the physician to collect his usual charge. Thus there could be no misunderstanding between the physician, patient, and insurance carrier as to whether such discussion had, in fact, taken place. Such a form is described as follows (although it could be varied to fit individual cases). This form or a similar form could be attached to the patient's record and a copy be available for the carrier.



JOHN DOE, M.D.  
110 Doctor's Street  
Anywhere, Indiana

Charges estimated in advance of surgery, obstetrics, etc.

Operation<sup>1</sup> \$

Assistant<sup>2</sup>

Anesthesia

1. Includes normal care and post-operative care. It should be understood this estimate is for normal, uncomplicated service. In the course of care, should complications require additional treatment, the total fee may be more than estimated.
2. The surgical assistant will bill the patient for his fee. When the referring physician acts as the assistant, he will bill the patient for his services.  
If additional medical care is required, the physician rendering this care will bill the patient for his services.

The service and payment therefore is a contract between you and I as your physician. I hold you responsible for full payment of all charges regardless of any amount that may be paid by your insurance plan.

I acknowledge receipt of a copy of this form and agree to the terms as set forth.

Signature \_\_\_\_\_

Because of the very apparent difficulties in communication with Blue Shield, the Commission on Medical Economics and Insurance recommends:

1. A direct line of communication with Blue Shield be established by the appointment of a liaison committee of the ISMA with Blue Shield—said committee to consist of the president, president-elect, chairman of the Board of Trustees, the chairman of the Commission on Medical Economics and Insurance and the executive secretary. This committee to meet regularly with the Blue Shield executive committee and the Blue Shield Board, as may be indicated.
2. As an alternative to Number 1, the Ad Hoc Committee be reactivated to serve as an ombudsman committee in matters between ISMA members and Blue Shield.

The Commission on Medical Economics and Insurance has reconsidered the matter of the establishment of Relative Value Schedules. It reiterates its state-

ment to the House of Delegates in 1971 that "the adoption of Relative Value Schedules be left to local option or to the option of specialty groups.

The Commission has been considering medical foundations and similar organizations for two years, primarily because of the possibility of legislative decision that may be forthcoming that will have a most undesirable effect on medical practice. The Commission will present a joint report with the Future Planning Committee to the House of Delegates. The Commission on Medical Economics and Insurance has come to the conclusion that the profession must have available some means by which it can make an effort to blunt the expected inroads into medical practice. Perhaps this can be done by the ISMA in the following manner:

1. Be prepared to establish a Professional Review Corporation that can encourage, cooperate with, and advise local medical review organizations or corporations as well as standing independently.
2. Such corporation should be initially limited to professional review; but be sufficiently flexible to be able to participate in claim review if this is deemed necessary by the Board of Trustees or the House of Delegates.
3. Under no circumstances shall such a corporation be involved in direct patient care or risk-sharing.

KENNETH O. NEUMANN, M.D.,  
Chairman

LEO R. NONTE, M.D.  
PAUL W. HOLTZMAN, M.D.  
EDWARD J. PLOETNER, M.D.  
THOMAS J. CONWAY, M.D.  
PAUL M. INLOW, M.D.  
FREDERICK EVANS, M.D.  
LARRY G. COLE, M.D.  
R. JAMES BILLS, M.D.  
JOHN L. FRAZIER, M.D.  
ROBERT STONE, M.D.  
JACK W. HANNAH, M.D.

(At Large)

MONICA WEBSTER (SAMA)

### Joint Report from the Commission on Medical Economics and Insurance and the Future Planning Committee

**HOUSE ACTION:** Adopted as amended. Referred to the Board of Trustees.

Inasmuch as both the Commission on Medical Economics and Insurance and the Committee on Future Planning were charged with the responsibility of making a study of foundations, it was decided that the two groups should meet together for a discussion of this subject. The meeting took place on July 9, 1972.

The headquarters office provided for study and review the Peer Review Manual prepared by the Council on Medical Service of the American Medical Association as well as innumerable articles and copies of foundation articles of incorporation and bylaws and of foundations established by other states and local groups.

Also reviewed was legislation before the present Congress and the pronouncements of several leaders in the Congress as to their thinking regarding some possible future developments in the health care system.

Realizing that the medical profession has a responsibility in the delivery of health care and that the medical profession should be the group responsible for overseeing the delivery of quality medical service to the people of our state, we, therefore, submit the following:

We recommend to this House of Delegates that they direct the Board of Trustees to establish a mechanism for a statewide corporation to provide for professional review and that the president be empowered to appoint a special committee to study and to prepare a plan to permit the establishment of such a corporation and to submit such a plan to the House of Delegates, at a special meeting if necessary, but not later than the next regular meeting of the House of Delegates.

We further recommend that this plan provide for cooperation with local or regional professional review committees, encourage the establishment of local or regional review committees and provide advice and help for local or regional committees.

We further recommend that this corporation be currently limited to professional review, but be flexible enough to be able to participate in claims review if this be deemed necessary by the House of Delegates.

Further we recommend that under no circumstances shall such a corporation be permitted to provide direct medical care or to participate in risk-sharing.



COMMISSION ON MEDICAL  
ECONOMICS AND INSURANCE  
Kenneth O. Neumann, Chairman  
COMMITTEE ON  
FUTURE PLANNING  
Lowell H. Steen, Chairman

## Medical Education and Licensure

### HOUSE ACTION: Approved.

**Recommendation:** Establishment of a special membership category known as **Distinguished Member**. Referred to Commission on Constitution and Bylaws. To be voted upon in 1973.

**Recommendation:** Adoption of the accreditation system for continuing medical education.

**Recommendation:** Approval in principle of the proposed Medical Practice Act to be referred back to Commission on Medical Education and Licensure. Final legal draft to be prepared and brought back to the next regular session of the House of Delegates for their consideration.

The Commission met on December 19, 1971, March 12, June 11, and September 10, 1972. In addition to the regular members in attendance, several guests and consultants also attended and participated in the work of the Commission. These included the ISMA president, Peter R. Petrich, M.D., and the president-elect, James Gosman, M.D. Also attending were Steven D. Berkshire, program coordinator for postgraduate education at the Indiana University School of Medicine, and SAMA representatives, Mr. Robert Green, Mr. Robert Daley, and Miss Jane Henney, the Indiana coordinator for SAMA-MECO Project. Dr. George Lukemeyer attended one meeting, representing the dean's office at the Indiana University School of Medicine. Dr. Earl Braunlin, ophthalmologist, and Mr. Bill Wehrenberg also attended one meeting as guests.

I. Work referred to the Commission by Action of the 1971 ISMA House of Delegates included Resolutions 71-14 and 71-15, as well as the proposed Uniform Medical Practice Act. Action on the referred business is as follows.

**A. Resolution 71-14, Encouraging Participation in Continuing Medical Education to Fulfill Requirements of the American Medical Association's Physician Recognition Award.**

1. The Commission recommends adoption of the following to encourage ISMA members to participate in continuing medical education:

a. Establish a new category of ISMA membership to be called "Distinguished Member," based on Fulfilling the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum. The ISMA membership card to be issued to the Distinguished Member should be distinctive, such as a gold card and properly identified as "Distinguished Member."

b. Provide an ISMA Award Seal to be attached to the AMA-PRA certificate and presented at the annual meeting to members fulfilling the minimum requirements.

c. Use the AMA-PRA report form with their categories of continuing medical education with the addition of a category accepting a specialty board recertification or proof of fulfilling a specialty group's continuing medical education requirements as evidence of meeting the minimum requirements for the Indiana Award.

**B. Resolution 71-15, Statewide continuing Medical Education Accreditation System.**

1. The Commission developed a Subcommittee on Continuing Medical Education as directed by this resolution. The work of this subcommittee included work on Resolution 71-14 as well as Resolution 71-15, since they are interrelated. The report of the subcommittee was approved by the Commission so that their recommendations are being made by the Commission. Members of the subcommittee and their organizations are listed as follows:

Robert Nagan, M.D. (American College of Surgeons)

Eugene M. Gillum, M.D. (Indiana Academy of Family Practice)

Victor H. Muller (Indiana Association of Pathologists)

Donald F. MacLeod, M.D. (Indiana Thoracic Society)

Iver Small, M.D. (Indiana Psychiatric Society)

Lewis F. Morrison (Indiana Academy of Ophthalmology and Otolaryngology)

Raymond O. Pierce, Jr. (Indiana Orthopaedic Society)

Richard Hamburger (Indiana Society of Internal Medicine)

William D. Dannacher (International College of Surgeons)

Jack H. Hall (AIDME)

Steven D. Berkshire (I.U. School of Medicine)

Steven C. Beering, M.D. (I.U. School of Medicine and Commission Member)

Jene R. Bennett, M.D. (Commission Member)

Ross L. Egger, M.D. (Commission Member)

Shokri Radpour, M.D. (Commission Member)

Norman J. Wilson, M.D. (Commission Member)

Franklin A. Bryan, M.D., (Commission Member)

2. The Commission recommends adoption of the following regarding an accreditation system:

a. The Commission will accredit programs, institutions, or organizations rather than individual courses or lectures. These will be in-state, non-university programs such as state medical, county medical society, local hospital, or voluntary health organizations. Accreditation will be requested by the agency developing and presenting the program.

b. When a program, institution, or organization has been accredited, it will be granted a certificate of accreditation for a specified period of time.

c. Accreditation will be based on fulfilling the AMA requirements as presented in the AMA "Essentials for Continuing Medical Education."

d. The system of accreditation will include the completion of a pre-survey questionnaire by the applicant program, institution, or organization, followed by a site visit inspection. The site visit team reports to the Commission and makes their recommendation. Temporary accreditation may be granted pending the site visit inspection if the pre-survey questionnaire appears to be satisfactory.

e. The subcommittee of the Commission should be maintained to aid in the implementation and



maintenance of the accreditation system.

f. All documents pertaining to the administration of the program have been developed and have been approved by the Commission and will be utilized in the conduct of the program when the accreditation plan is approved by the ISMA House of Delegates.

#### C. Proposed Uniform Medical Practice Act.

1. The Commission presented the proposed Uniform Medical Practice Act at four hearings over the state, inviting all ISMA members to participate. Members of the Indiana Association of Osteopathic Physicians and Surgeons and their attorneys were invited also and participated. Dr. Merritt Alcorn and the Commission chairman attended all hearings and presented the material while other members of the Commission attended in their districts and helped in the necessary arrangements. All hearings were recorded and transcribed and all suggestions are being considered in rewriting the proposed Act for Indiana for presentation to the ISMA for their action.

2. The hearings were held in Fort Wayne on April 4 and 5, in Evansville on April 11, in Gary on May 3 and in Indianapolis on May 16.

II. Some other subjects and problems considered by the Commission were (A) Indiana University School of Medicine, (B) Student-Faculty-ISMA Retreat, (C) SAMA, (D) Family Practice Preceptorship.

#### A. Indiana University School of Medicine.

1. As in past years, a very close liaison between the medical school and the Commission existed. At each meeting one or more representatives of the dean's office were in attendance to report on the status of the school and to answer questions. They have worked on the subcommittee for continuing medical education and accreditation and have contributed much.

#### B. Student-Faculty-ISMA Retreat.

1. The Commission worked closely with the medical school faculty and students in planning the Student-Faculty-ISMA Retreat. The ISMA

representative on the planning committee was Commission member, Dr. Ross Egger. The results of the Retreat and recommendations were tabulated and will be presented to the Commission and the Indiana State Medical Association.

#### C. SAMA.

1. Representatives of SAMA attended the meetings and presented their viewpoints on several subjects. In addition to the Retreat they presented the SAMA-MECO Project for information and the subject of the student-evaluation system of the medical school. In addition, the student representatives were most helpful in their discussions on many subjects.

#### D. Family Practice Preceptorship.

1. This program was carried out this year in cooperation with the Family Practice program of the Indiana University School of Medicine. Dr. Ross Egger represented the Commission on the Preceptor Committee. Under the new structure the program is much better organized than in the past.

Many other subjects were studied and acted upon by the Commission, including the physician assistant and legislative matters presented at the last legislature.

The Chairman thanks all the members of the Commission for their participation in the work during the year. The Chairman also thanks all of the consultants and guests who have contributed much to the work of the Commission. The Subcommittee on Accreditation deserves the gratitude of the Commission for the many hours dealing with continuing medical education and accreditation.

The Commission thanks the ISMA staff, specifically Mr. Ken Bush and Mrs. Mary Alice Cary, for their outstanding support and extra effort in helping with the large volume of work this year which could not have been possible without their assistance.

FRANKLIN A. BRYAN, M.D.,  
Chairman

ROSS L. EGGER, M.D.,  
Vice Chairman

NORMAN WILSON, M.D., Secretary  
GILBERT HIMEBAUGH, M.D.

BETTY DUKES, M.D.

DANIEL CANNON, M.D.

GEORGE G. MORRISON, JR., M.D.

STANLEY FRODERMAN, M.D.

DAVE ELLIS, M.D.  
DONALD M. SCHLEGEL, M.D.  
SAMUEL C. MILLS, M.D.  
SHOKRI RADPOUR, M.D.  
JENE R. BENNETT, M.D.  
MERRITT O. ALCORN, M.D.  
PETER J. PILECKI, M.D.  
GLENN W. IRWIN, JR., M.D.  
STEVEN C. BEERING, M.D.  
ROBERT GREEN (SAMA)

### Supplemental Report, Commission on Medical Education and Licensure

**HOUSE ACTION:** Referred to the House by the Board of Trustees without recommendation.

Approved by the Reference Committee. ISMA to commend I. U. School of Medicine and pledge continued support to the University for its outstanding work in the field of postgraduate medical education as well as for its total program in the statewide program. Student-Faculty-Physician Retreat to be continued on an annual basis.

At its last meeting on September 10, 1972, the Commission on Medical Education and Licensure completed its business and made recommendations which are offered here as a supplement to its annual report:

(1) The Commission recommended that the Indiana State Medical Association commend the Indiana University School of Medicine and pledge continued support to the university for its outstanding work in the field of postgraduate medical education as well as for its total program in the statewide system.

(2) The report of the Student-Faculty-ISMA Retreat (*JISMA* Sept. 1972, pp. 931-933) was studied and, by action of the Commission, is to be added to the supplemental report as an appendix. Proper implementation of the report will be made through presentation to the Dean's Office and by the Commission on Medical Education and Licensure, with the approval of the House of Delegates. Many of the recommendations in the report applying to the medical school have already been carried out or are under consideration. The Commission recommends that another Retreat be held next year.

(3) Family Practice Program. The Commission studied the report of the Preceptorship Committee and is considering methods of increasing the utilization of this program.



(4) The proposed Medical Practice Act was reviewed in its new form, following the mandated hearings over the state as well as the article in *The Journal of the ISMA (JISMA*, August 1972, pp. 859-860). The proposed Act was approved in principle by the Commission and referred to the Board of Trustees of the Indiana State Medical Association for their review and recommendation to the House. The preliminary draft of the proposed new Act has been distributed to the House of Delegates for their information and review. It is hoped that the delegates will offer suggestions and criticisms of this preliminary draft.

(5) A legal opinion was obtained for the Commission by the ISMA legal counsel, who states that interns and residents should have liability insurance above that provided by the hospital.

(6) The new physician assistant program at the Fort Wayne Center for Medical Education was discussed. Twelve students are enrolled in the two-year program to train assistants to the primary-care physician. This program follows the AMA Essentials.

## Proposed Medical Practice Act

*(This draft is not in final legal form.)*

### I. Purpose

A general statement of policy shall introduce the act and shall emphasize the following facts:

It is deemed necessary as a matter of policy in the interest of public health, safety and welfare to provide laws and provisions covering the granting of licenses to practice medicine or osteopathy, and their subsequent use, control and regulation to the end that the public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice of medicine or osteopathy, and from unprofessional conduct by persons licensed.

### II. Definitions

The definition of the "Practice of Medicine or Osteopathy" means:

(a) to diagnose, treat, correct, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other conditions, physical or mental, real or imaginary, by any means or instrumentality.

(b) to maintain an office or place of

business for the purpose of doing acts described in clause (a) whether for compensation or not.

(c) to use, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions, the designation "Doctor," "Doctor of Medicine," "Doctor of Osteopathy," "D. O.," "Osteopathic Medical Physicians," "Physician," "Surgeon," "Physician and Surgeon," "Dr.," or "M.D.," or any combination thereof unless such a designation additionally contains the description of another branch of the healing arts for which a person has a license.

The definition of "Board" means the State Board of Medical Registration and Examination of Indiana.

The definition of "Diagnose" means to examine in any manner another person, parts of a person's body, substances taken or removed from a person's body, or materials produced by a person's body to determine the source or nature of a disease or other (abnormal) physical or mental condition, or to hold oneself out or represent that a person is so examining another person. It is not necessary that the examination be made in the presence of such other person; it may be made on information supplied either directly or indirectly by such other person.

The definition of "drug" or "medicine" means (all medicines and preparations) any compound, chemical or biological preparation intended for internal or external use of man, (and all substances) or intended to be used for the diagnosis, cure, mitigation or prevention of diseases or abnormalities of man, which are recognized in the latest editions published of the United States Pharmacopoeia or National Formulary, or otherwise established as a drug(s) or medicine.

The definition of "licensee" means an individual holding a valid license issued by the Board.

The definition of "prescribe" means to direct, order or designate the use of or manner of using a drug or medicine or treatment, by spoken or written words or other means.

#### A. Exceptions to the Act:

1. The act shall not have application to a student in training in a professional school approved by the Board while performing the duties of an intern or similar function in a hospital under the supervision of its staff.

2. The act shall not have application to students who have had training in an approved school of medicine or osteopathy and who are continuing

their training and performing the duties of an intern or engaged in post-graduate work deemed the equivalent of an internship by the Board in any hospital or institution maintained and operated by a state or territory of the United States, or in any hospital within a state or territory operating under the supervision of a medical staff, the members of which are licensed to practice medicine or osteopathy and which hospital is approved for internship by a state or territorial licensing agency.

3. The act shall not apply to the rendition of service in cases of emergency where no fee or other consideration is contemplated, charged or received.

4. The act shall not be construed to apply to commissioned medical officers of the Armed Forces of the United States, the United States Public Health Service, and Medical Officers of the Veterans Administration of the United States in the discharge of their official duties.

5. The act shall not apply to an individual residing in another state or country and authorized to practice medicine or osteopathy there who is called in consultation by an individual licensed to practice medicine or osteopathy in this state.

#### B. Exclusions from the Act:

1. The definition of the practice of medicine or osteopathy shall not apply to a person licensed to practice a limited field of the healing arts which constitutes a part of the practice of medicine or osteopathy and the provisions of an act shall never be construed to affect in any manner the practice of the religious tenets of any church or religious belief. The definitions of the practice of medicine or osteopathy shall not include an individual administering a domestic or family remedy to a member of his family.

2. This act does provide for the use of professional and domestic nursing.

3. Registered nurses may administer anesthesia under the direction of and in the immediate presence of a licensed physician, provided each nurse has taken a prescribed course in anesthesiology.

4. Physician Assistants. This act does provide for the use of physician assistants, by authorizing a physician to delegate any of his acts, tasks, or functions to qualified assistants performing under his direction and super-



vision, provided that: (a) the physician assistant is certified by a registry approved by the Board or is a graduate of an institution approved by the Board, and (b) the physician employing the physician assistant has the approval of the Board for such employment.

### **III. Establishment of Board and its Composition** (as now constituted)

### **IV. Recommendations of Licensure Requirements**

The Board shall have authority to prescribe and establish rules and regulations to carry into effect provisions of the act, including but without limitation, regulations prescribing all requisite qualifications of education, residence, citizenship, training and character for admission to an examination for licensure or by endorsement for licensure.

#### **A. Minimum requirements shall be:**

1. That the applicant be at least 21 years of age.

2. That he or she is a citizen of the United States, or has filed a petition for naturalization or, not having fulfilled the residence requirements for naturalization, has declared intention to become a citizen of the United States.

3. That the applicant be of good character.

4. That the applicant received the degree of Doctor of Medicine or Doctor of Osteopathy or its equivalent from a college or school in the United States, its possessions or Canada which was approved by the Board as of the time this degree was conferred.

5. That the applicant is physically and mentally capable of safely engaging in the practice of medicine or osteopathy and will submit to an examination deemed necessary by the Board to determine such capability.

6. That an applicant has not been guilty of any conduct which would constitute grounds for refusal, probation, suspension or revocation of license under the regulations of the Board involved. This action may be modified at the discretion of the Board.

7. The applicant has not had his license revoked or suspended by the Board by reason of his ability safely to practice medicine or osteopathy.

8. That the applicant made a personal appearance before the Board at the discretion of the Board.

B. Fees for licensure shall be determined by the Board.

C. Biennial renewals of registration shall be required.

### **V. Examinations**

The Board has the authority to adopt rules and regulations relative to examinations.

(a) The Board shall prepare and give, or approve the preparation and giving, of an examination which shall cover those general subjects and topics, a knowledge of which is commonly and generally required of candidates for the degree of Doctor of Medicine or Doctor of Osteopathy or its equivalent conferred by approved colleges or schools of medicine or osteopathy of the United States, its possessions or Canada.

(b) Examinations shall be given in such a way that persons grading the papers shall have no knowledge of the identity of an individual being examined.

(c) Examinations shall be conducted at least semi-annually, provided there are applicants.

(d) The candidates minimum general average for licensure shall be 75%.

### **VI. Licensure of Graduates of Foreign Medical Schools.**

1. Qualifications for admission to examination:

To procure a regular license to practice medicine, an applicant who is a graduate of a school of medicine located elsewhere than the United States, its possessions, or Canada shall submit satisfactory proof to the Board that he meets all the requirements:

(a) That an applicant meets all the requirements of Section IV, except for paragraph 4.

(b) That an applicant has received the degree of Doctor of Medicine or its equivalent from a foreign medical college determined by the Board to be acceptable.

(c) That an applicant has the working ability to read, write, speak, understand and be understood in the English language.

(d) That he has completed a minimum of two (2) years' graduate training satisfactory to said Board in a hospital or institution located in the United States or Canada, meeting the standards approved by the nationally recognized medical or osteopathic accrediting bodies in the United States, for the purpose of graduate training.

2. Type of Licensure:

(a) Foreign medical graduates suc-

cessfully meeting requirements for licensure in the state of Indiana either by examination or endorsement will be given a provisional license for a period of two (2) years.

### **VII. Licenses without Examination**

A. Endorsement: The Board may issue a license by endorsement to an applicant who has complied with licensure requirements and who has passed an examination for licensure to practice medicine or osteopathy in all their branches in any other state or territory of the United States or Canada, provided that the examination endorsed was, in the opinion of the Board, equivalent in every respect to its examination. In the case of a graduate of a foreign medical school, the applicant must have met all the requirements of Section VI.

B. Certifying Agency Examinations: The Board may in its discretion endorse an applicant who has complied with licensure requirements and who has passed an examination given by a recognized certifying agency approved by the Board, provided such examination was, in the opinion of the Board, equivalent in every respect to its examination.

C. Temporary Permits: The Board may issue Temporary Permits to provide for the practice of medicine and osteopathy in the interval between Board meetings and to meet specific needs. If a Temporary Permit is issued, it is subject to an automatic termination date specified by the Board.

D. The Board, in certain exceptional instances, may waive for final licensure any of the provisions herein contained, provided, however, that this Board action shall be taken only after a complete evaluation of the candidates' previous training, education and practice which is determined by the Board to equal or exceed the requirements of the above provisions herein.

### **VIII. Retirement and Surrender of License**

A person licensed to practice medicine or osteopathy in this state may retire from practice by notifying the Board in writing of his intention to retire. Upon receipt of this notice the Board shall record the fact that the person is retired and excuse such person from further payment of registration fees. If a person surrenders his license to practice medicine or osteopathy in this state, his reinstatement may be considered by the Board on his written request.



## **IX. Grounds for Probation, Suspension or Revocation of License**

To promote more endorsement and reciprocity between the several states and territories and to provide guidelines for the practitioners and the Board, the following charges will be grounds for probation, suspension or revocation of licenses.

- (a) The use of any false, fraudulent or forged statement or document, or the use of any fraudulent, deceitful, dishonest or immoral practice in connection with any of the licensing requirements.
- (b) The conviction of a felony.
- (c) Becoming addicted to a drug or intoxicant to such a degree as to render the licensee unsafe or unfit to practice medicine or osteopathy.
- (d) Suffering from a mental or physical disability to such a degree as to render the licensee unsafe or unfit to practice medicine or osteopathy.
- (e) Except as otherwise permitted by law, knowingly prescribing, selling or administering any drug classified as a narcotic, addicting or dangerous drug to a habitue or addict.
- (f) Gross carelessness or manifest incapacity in the practice of medicine or osteopathy.
- (g) The practice of medicine or osteopathy under a false or assumed name, or the willful performance of an act likely to deceive or harm the public. The individual bringing charges or testifying before the Board shall be immune from prosecution by the accused if the charges or testimony were not brought with malicious intent.

## **X. Definition of Unlawful Practice of Medicine and Osteopathy and Violations and Penalties**

It shall be unlawful for any person to do or perform any act which constitutes the practice of medicine or osteopathy as defined without first having obtained a license to practice medicine or osteopathy.

It is recommended that a person, corporation or association which violates the provisions of the Medical Practice Act or an officer or director of a corporation or association causing or aiding and abetting such violation shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for a term not exceeding two years or by a fine not exceeding \$1,000 or by both such fine and imprisonment.

## **XI. Proceedings for Probation, Suspension or Revocation**

A procedure shall be enacted placing full authority for proceedings in the Board. The Board shall have discretion concerning probation, suspension and revocation. The findings of the Board shall be subject to review by courts, but the court's authority shall be limited to sustain or reverse a decision, not to modify.

In any hearings conducted under this section, the accused shall be granted the right to appear in person or by attorney and to introduce testimony in his behalf. He shall also have the right to have witnesses, books, papers and documents subpoenaed for him by the Board upon due application. Legal rules on introduction of evidence shall not bind the Board. The Board shall consider all testimony, exhibits, documents or evidence presented in support of the charges or by the accused. The Board shall consider the credibility of any indirect evidence submitted. Any objections to testimony and the reasons therefor shall be noted in the record and transcribed along with the testimony.

Pending appeal from a revocation of a license issued by a medical board, the licensee shall be prohibited from the practice of medicine or osteopathy until the appeal is finally determined.

## **XII. Injunction Clauses**

In cases where an accused is deemed harmful to the public or himself, the Board may appeal to the court of jurisdiction to enjoin the accused from practicing medicine or osteopathy until the citation hearing is completed and a decision rendered.

## **XIII. Rules and Regulations to be Adopted by the Board.**

The Medical Practice Act shall authorize the Board to adopt rules and regulations to carry into effect the provisions of its Medical Practice Act.

## **Special Activities**

**HOUSE ACTION: Ordered filed. Resolution contained in report endorsing Formation of Group Practices in the state of Indiana referred to Board of Trustees for reevaluation.**

During the 1971-72 year the Commission on Special Activities made significant headway in two important areas of topical interest and concern: drug ad-

diction and rural health. In our deliberations we much appreciated the presence and opinions of Dr. Peter Petrich, president, and Dr. James Gosman, president-elect of ISMA, and the special expertise brought to our meetings by a number of invited eminent guests who freely gave of their time. They included, among others, Dr. William Murray, State Commissioner of Mental Health; Dr. Frank Osberg, Director of Drug Abuse Division, State Department of Mental Health; Dr. Richard D. Hawkins, President of the Bedford Medical Center; Dr. A. Alan Fischer, Director, Family Practice Program, Indiana University School of Medicine; Drs. Eli Goodman and Dwight Schuster, members of our Board of Trustees; and Mr. Michael Quinn, Executive Director of the Community Addiction Services Agency, Inc. (CASA).

The Commission referred to the Board of Trustees the following memorandum from Dr. Alan Fischer with a recommendation that it be supported.

"The Board of Trustees of Indiana University approved the development of a Family Practice Program at IUMC and named Dr. A. Alan Fischer director in February 1971. He was charged to develop the Family Practice curriculum, secure faculty, and develop the entire structure for academic teaching of Family Medicine at the undergraduate, graduate, and postgraduate years. When accomplished, a full Department of Family Medicine was to be formed and Doctor Fischer was to be the first department chairman.

"The above has been carried out to the point that only funds are now blocking the full implementation of the Family Practice Program at Indiana University, due to the last legislature's severe cut in university funding. There are at present no funds available to begin the Family Practice Program. It is hoped that some money will soon be available through the Health Manpower Assistance Act and the Family Practice Act, but if such funds are not available by January 1, 1973, it is hoped that emergency legislation will be introduced and passed by the State Legislature. A Bill for this purpose is now being formed and modeled after other states which have been forced to go this route for financing their Family Practice Departments. Although there are university reasons for firmly opposing special categorical funding legislation for medical schools, I.U. does not oppose this as a needed measure for the



Family Practice Department. The help of this Commission on Special Activities in bringing this problem to the attention of the ISMA would be greatly appreciated. The support of the ISMA when this legislation comes before the legislature would be of tremendous help. I am, therefore, suggesting that the ISMA issue a statement strongly supporting the Department of Family Medicine at Indiana University as suggested above."

In the area of drug abuse, the Commission was actively engaged in the planning of a two-day Drug Training Institute, to be chaired by Dr. Hanus Grosz, at Stouffer's Inn, Indianapolis. The program, scheduled for July 12 and 13, 1972, was co-sponsored by ISMA, Indiana Department of Mental Health, the Indiana Academy of Family Practice and Pfizer Pharmaceuticals, which has very generously taken on the financial burdens of the Institute.

The recently formed subcommittee on Drug Addiction and Alcoholism, chaired by Dr. Dwight Schuster, reviewed the role of ISMA in drug education and came up with a number of recommendations: one, that ISMA distribute to its membership an existing manual on the "Treatment of Acute Drug Intoxication"; two, that ISMA and the county medical societies be presented with a directory of drug clinics and drug programs in Indiana to be used as a source of referral information; and three, that ISMA assist the county medical societies with speakers and programs on drug abuse.

Finally, the Commission appointed a subcommittee on rural health. Members of the subcommittee were Richard D. Hawkins, M.D., Bedford, chairman; Hanus Grosz, M.D., James H. Gosman, M.D., George M. Ellis M.D., Eli Goodman, M.D., Donald Hunsberger, M.D., and John C. Linson, M.D.

The Committee has actively studied the problems of physician recruitment and health care delivery in rural and non-metropolitan areas of Indiana during 1972. These studies have consisted of probing meetings with representatives of the Indiana State Board of Health, the Comprehensive Health Planning Agency, the Indiana State Board of Health, the Indiana Regional Medical Program and the I.U.-P.U. School of Medicine. The medical school representatives consisted of the directors of the Family Practice Department and the Department of Community Health Sciences as well as medical students. In addition, the

Family Medicine Department of Methodist Hospital of Indianapolis and the layman consumer of health care were represented.

The committee has summarized its findings as follows:

1. An insufficient number of primary care physicians are entering practice as solo practitioners in the rural and non-metropolitan areas of Indiana to meet the consumers' need.
2. Solo practice is and will remain an important entity in the delivery of health care in Indiana. However, the committee finds that interest in this type of practice is on the decrease in recent graduates both in Indiana and throughout the country. This fact is more specific as it pertains to practice in non-metropolitan areas.
3. There is a great need at the medical school and graduate levels of medical education for the enthusiastic encouragement of the primary care specialties, more specifically, the encouragement of physicians to enter the fields of Family Practice, General Pediatrics and General Internal Medicine. It is suggested that this could be better accomplished by the presence of instructors in these fields with contagious attitudes of enthusiasm and the elimination of the uncomplimentary vocal opinions concerning "L.M.D.'s" emanating from many resident staffs.
4. In areas of non-metropolitan Indiana where group medical practices exist there is a good supply of physicians and there is undeniable evidence that physician recruitment is successful. It is also suggested that there is an improved supply of solo practitioners in some of these areas.
5. There is evidence that new and modern hospital facilities alone do not attract physicians. These facilities are an absolute requirement but are not successful unless accompanied by an organized recruitment effort. The facts reveal that adequate and modern facilities coupled with group medical practice is the successful formula at the present time.

The committee recommended to the Commission on Special Activities of the Indiana State Medical Association that the following resolution be submitted to the Board of Trustees of the Indiana State Medical Association for possible

adoption at the 1972 meeting of the House of Delegates. The Board adopted the resolution.

BE IT RESOLVED that the Indiana State Medical Association endorses the formation of Group Medical Practices in the State of Indiana as means to improve the supply of physicians and to improve the delivery of health care in certain problem non-metropolitan and rural areas. The term Group Medical Practice, as herein used, is defined by the American Medical Association as follows:

"Group Medical Practice is the application of medical service by three or more physicians formally organized to provide medical care, consultation, diagnosis, or treatment, through the joint use of equipment and personnel, and with income from medical practice distributed in accordance with methods previously determined by members of the group"

FURTHER, the Indiana State Medical Association shall support the implementation of the formation of such Group Medical Practices in problem areas of the state through the authorization of the appropriate Commission and committees by the Board of Trustees to assist involved communities, county medical societies and related planning and development groups.

FURTHER, the Indiana State Medical Association encourages that such Group Medical Practices be formed from nuclei of physicians that have established practices in the involved community and who exhibit cooperative interest in the formation of group practice in an effort to attract needed physicians and to improve available health services to the consumer in the area.

FURTHER, the Indiana State Medical Association continues to endorse the Solo Practice of Medicine, inasmuch as many physicians prefer this method of practice and cannot suitably adapt to the requirements that are necessary for the successful operation of Group Medical Practice.

FURTHER, the Indiana State Medical Association finds no evidence that the existence of Group Medical Practices in Indiana or in other states compromises the position of the Solo Practitioner and that the Solo Practitioner will continue to be an important part of the Health Care Delivery System in America.

HANUS J. GROSZ, M.D. Chairman  
RICHARD B. HOVDA, M.D.  
WILLIAM H. GARNER, Jr., M.D.  
JOHN C. LINSON, M.D.



FRED E. HAGGERTY, M.D.  
 DONALD HUNSBERGER, M.D.  
 THOMAS J. STOLZ, M.D.  
 ADOLPH WALKER, M.D.  
 NORMAN BEAVER, M.D.  
 EVERETT DONNELLY, M.D.  
 PETER E. GUTIERREZ, M.D.  
 (At Large)  
 ROBERT P. ACHER, M.D. (At Large)

## COMMISSION STATEMENT ON HEALTH CARE IN NURSING HOMES

It is high time, in the opinion of the Indiana State Medical Association's Commission on Aging, that citizens of this state are apprised of the erosion in the health care which is allowed Medicare and Medicaid patients in nursing homes and of the frustrations of physicians thwarted in their efforts to provide quality service to them.

Experience with the Medicare and Medicaid programs has revealed glaring deficiencies; some built into the concepts of the programs and others complicated by restrictions of benefits, but all at the expense of the patient and the physician trying to take care of him.

Thus it is imperative, the Commission believes, that the medical profession and operators of extended care facilities offer recommendations; hopefully, to bring about changes in a situation which is becoming unbearable or, if unavailing, to have the conclusions of these experts a matter of written record.

The privilege of attaining old age is not given to everyone, but the number of persons reaching it is increasing. It is unconscionable, then, that provision of their health care is sinking in a bog of federal regulations established to make that care fit the money available and not to insure its quality. It is equally unconscionable to expect dedicated physicians to labor under regimentation which limits so severely their ability to provide adequate care that many elect not to participate at all.

The political promise of health care for all the aged, regardless of need, may have been well-intended. Certainly it was politically expedient. Performance, however, has proved to be miserable. Congressional disregard of repeated warnings that the cost of such programs was woefully underestimated, especially when Medicare was designed to embrace everyone over 65 instead of just the needy elderly, has come home to roost.

"Cost containment" now has become paramount, regardless of the fact that patient benefits are increasingly restricted, that care in custodial facilities is not covered, and that "containment" infers that physicians have found a windfall in care of the elderly in nursing homes, thus tarring all for the transgressions of extremely few.

Consider: When a convalescent patient leaves a hospital, application must be made to an extended care facility. This involves paperwork, telephone calls,

consultation with relatives and orders, among other things, for the doctor. If the patient is accepted, the physician must visit him within 48 hours, and must see him again in two weeks. The physician receives a fee for one visit only, and that is reduced if he sees other patients in the facility at the time, and the patient is subjected to a transition from frequent medical supervision to a monthly visitation unless the doctor can substantiate, by additional paperwork, that additional visits are medically necessary.

It is a nurse, or clerk, however, who rules on the substantiation and in precious few cases is it approved. Thus, a decision made by Medicare or Medicaid intermediary (Blue Shield, in Indiana) certainly overrides a physician's medical knowledge and judgment, leaves the patient without adequate care, and repels the doctor. Few doctors are inclined to accept such treatment and to accept reduced fees in addition. And, as a final blow to the patient and his family, the length of stay in hospitals or extended care facilities for which the federal programs will pay is severely limited. The disenchantment becomes complete.

With the foregoing, albeit cursory, in mind, the Commission makes the following recommendations to correct an intolerable state of affairs:

1. Remove all but the needy elderly from eligibility for Medicare and apply the moneys thus husbanded to proper medical, extended care and custodial care for the indigent.

2. Publicize widely, thereafter, to doctors and patients and their families what Medicare and Medicaid will, and will not cover.

3. Eliminate duplication of inspections and audits of nursing homes and reduce the paperwork now required to a minimum.

4. Provide for blanket allocations of funds to extended care facilities to cover medical fees, nursing services, drugs, food and shelter, thus ending dictation of the federal government and its regulations, and making local operations and services a matter for local decision.

5. Provide for peer review by local medical societies to insure against abuses and to remove medical decisions from lay control.

6. Finally, establish a central office, manned by knowledgeable employees of the Social Security Administration, Blue Shield and the Department of Public

## Aging

### HOUSE ACTION: Ordered filed.

The Commission met on November 21, 1971, March 12, May 21, and July 9, 1972.

The Commission agreed that Joel W. Salon, M.D., would represent the Indiana State Medical Association at the White House Conference on Aging in Washington, D.C., and that he express the Indiana State Medical Association statement of policy on aging as stated in the 1971 report of the Commission.

The Commission engaged in lengthy discussions on the medical care of the aged in the office, home and nursing home and on the dignity of the aged in death and dying.

A motion carried that the Commission Report on Nursing Homes, submitted to the Executive Committee and to the Board of Trustees, and the Commission-adopted Indiana State Medical Association Policy Statement on Death be made a part of the 1972 annual report of the Commission.

## INDIANA STATE MEDICAL ASSOCIATION STATEMENT OF POLICY ON DEATH

1. Aging is a natural process of life.
2. Death is a natural result of many disease and/or degenerative processes.
3. The science of medicine is able, at best, to postpone death.
4. Inability to live satisfactorily is by many considered to be less desirable than death.
5. The responsibility of the physician is to outline from available information the quality of life that can be expected.
6. The individual whose life is at stake should have an opportunity to take part in plans regarding his chances of recovery to lead a satisfactory life.
7. It is the moral responsibility of the physician to prolong life except when there is no chance of the sufficient recovery of the patient to lead a satisfactory life unless, in such case, the patient or a responsible relative requests that life and breath be maintained by extraordinary means.



Welfare, where a patient, his relatives, or a physician can obtain correct information at one source and not be referred to one office after another.

WALLACE R. VANDENBOSCH, M.D.,  
Chairman  
JOHN D. WILSON, M.D.  
RAYMOND DUNCAN, M.D.  
A. W. CAVINS, M.D.  
ALBERT M. DONATO, M.D.  
THEODORE R. HAYES, M.D.  
DANIEL RAMKER, M.D.  
JAMES McLAUGHLIN, M.D.  
JOEL W. SALON, M.D.  
DANIEL G. BERNOSKE, M.D.  
(At Large)  
MR. MICHAEL BUBB (SAMA)

## Emergency Medical Services

### HOUSE ACTION: Ordered filed.

The Commission met several times during the year and considered a number of items in the area of emergency medical services.

The Commission discussed the result of the survey which had been made of all Indiana hospitals concerning the equipment being utilized in their emergency rooms and sent the summary report to the following groups: Hospitals and Institutional Services, Division of the Indiana State Board of Health; secretaries of all county medical societies; Commission on Emergency Medical Services members; members of the Emergency Medical Services State Advisory Committee; Chiefs of Hospital Staffs; health officers in the state; secretaries of district medical societies; hospital administrators; secretary of the Indiana State Board of Health; the Indiana Department of Transportation; and the local Department of Health Education and Welfare.

On Sunday, January 23, the Commission met with representatives of a number of organizations to discuss the role of the helicopter in Indiana emergency disaster medical services. The following representatives were invited to this meeting: The Indiana Association of Fire Chiefs, the Indiana Association of Police Chiefs, Indiana National Guard, State Police, State Highway Commission, Grissom Air Force Base, Fort Benjamin Harrison, Civil Air Patrol, American Red Cross, State Sheriff's Association, Office of Traffic Safety, Indiana State Board of Health, and a number of chairmen from the Governor's Advisory Committee on Emergency Medical Services. Also invited were Indiana General Assembly senators and

representatives who were serving on various committees in the Assembly structure concerned with public health matters.

The meeting which followed was an extraordinary one since exchange of information was technically revealing on the capabilities of helicopters in various classifications.

Following the meeting and after a very serious discussion of the role, the Commission adopted the following statement as a policy:

"It does not appear feasible at this time to consider the development of a medical helicopter service for the State either on a public or private basis. Medical helicopter support will have to be obtained from a separate helicopter support system such as that proposed by the Indiana State Police or that provided by the military. Heliports and helipads should be developed on a gradual basis starting with the larger hospitals and as the air-ambulance system develops."

In summary of the year's activity of the Commission, the Commission wishes to recommend the following points as vital considerations by the Indiana State Medical Association in the area of emergency medical services:

- (1) There should be a more vigorous approach to the improvement of the services available in hospital emergency departments.
- (2) There must be an upgrading of ambulance service because this service is the real backbone of transportation of the patient with an emergency problem. ISMA should lend a much more active support to the ambulance bills which will be coming before the legislature by reviewing this legislation, carefully, and offering alternative proposals, such as discussed by the Commission during the year, should the need seem to be appropriate.
- (3) An active program should be instituted in emphasizing the importance of construction and maintenance of heliports and pads. A program is being coordinated with the superintendent of State Police to establish model plans for development of helipads and necessary maintenance criteria.
- (4) The Commission is convinced that helicopters will play an ever-increasing role in transporting the emergency medical patient from the scene of emergency to the hospital and also from the hos-

pital to other hospitals with more specialized services.

In view of the fact that the Indiana State Medical Association has supported, in cooperation with other organizations, an ambulance bill which has failed in the last two legislatures, the Commission considered an alternative proposal in this particular area of legislation, which is included in the minutes of the meetings of the Commission.

The Commission feels that the bill which has failed is perhaps all-encompassing and that more gain could be accomplished in the State Legislature by submitting a bill which would request legislation on some or part of the total need.

The Commission suggests that the Commission on Legislation of the Indiana State Medical Association give consideration to this suggested bill, as outlined by the Commission, should it appear that, once again, this much needed legislation appears headed for defeat in 1973.

CLEON SCHAUWECKER, M.D.  
Chairman (At Large)  
FORREST J. BABB, M.D.  
NEAL E. BAXTER, M.D.  
ROBERT M. BROWN, M.D.  
JOHN S. FARQUHAR, JR., M.D.  
JAMES D. FINFROCK, M.D.  
DONN R. GOSSOM, M.D.  
WILLIAM F. KERRIGAN, M.D.  
JAMES W. KRESS, M.D.  
RAYMOND W. NICHOLSON, M.D.  
WILLIAM F. NOWLING, M.D.  
JOHN G. SUELZER, M.D.  
(At Large)  
HOWARD S. WILLIAMS, JR., M.D.  
MR. BRUCE P. WILLIAMS (SAMA)

## Report of Special Reference Committee

### HOUSE ACTION: Approved.

Your Special Reference Committee met from 10:00 a.m. until 12:42 p.m. in Room 210 at the Indiana Convention-Exposition Center. Approximately 100 persons were there to give testimony which was diverse in content and provided the Reference Committee with much valuable information. In consideration of the importance of the positive materials presented, we feel that this House cannot possibly give appropriate attention to all the materials discussed and do justice to the importance of these materials. Certain information provided to your Committee has been previously provided to other reference committees.



It was the consensus of your Reference Committee that the positive favorable testimony was more abundant than critical testimony.

In attendance were three members of the AMA Board of Trustees: John H. Budd, M.D. of Ohio, Raymond T. Holden, M.D. of Washington, D.C., and Donald E. Wood, M.D. of Indianapolis. These gentlemen contributed much to the deliberations and obtained information which will be discussed in the future by the AMA Board of Trustees and, hopefully, transmitted into positive action.

Your Reference Committee considered the following items:

1. Orientation of the young physician in the state and county medical society.
2. The AMA relationship to state organizations as well as to other national organizations.
3. Medical politics.
4. The comparative role of the physician and the hospital.
5. National health insurance programs, Medicare and Medicaid.
6. Blue Shield and other health insurance companies.
7. Physicians involvement in organized medicine.
8. Public relations and physician relations.
9. Available educational materials for the physician and for the patient.
10. Legislative influence by the medical profession.
11. More effective implementation of constructive programs.
12. Dues structures for organized medicine.
13. The democratic process of organized medicine.

#### RECOMMENDATION NO. 1

It is the unanimous opinion of your Reference Committee that further serious consideration and deliberation of these items should be referred to the Future Planning Committee for careful scrutiny and referral *through* the Board of Trustees and/or president to the appropriate committee or commission of ISMA.

#### RECOMMENDATION NO. 2

We recommend that this Special Reference Committee, since it was well-attended and such a constructive session, be a continued function of the Indiana State Medical Association's annual convention as long as it serves a purpose for the Association.

#### RECOMMENDATION NO. 3

We further urge that pertinent material be circulated to the county medical societies so that they, too, may consider implementation.

We wish to thank all of those who attended the Special Reference Committee meeting to give valuable testimony and opinions. We likewise express our appreciation to Drs. Budd, Holden and Wood for their participation. Your chairman wishes to thank the members of the Reference Committee for their participation and their dedicated service to the committee and to Mrs. Mary Alice Cary who served faithfully as secretary.

LOWELL H. STEEN, M.D., *Chairman*  
HUGH K. THATCHER, JR., M.D.  
GILBERT M. WILHELMUS, M.D.  
JOHN W. BEELER, M.D.  
EARL R. LEINBACH, M.D.  
RICHARD D. HAWKINS, M.D.

#### Proper Certification of Delegates

##### HOUSE ACTION: Referred to Board of Trustees for implementation.

The Committee on Rules and Order of Business brought to the attention of the House that some of the credentials of delegates are not properly signed by the secretaries of the county medical societies prior to the annual convention, in accordance with Chapter IV, Section 2 of the Constitution. A motion was duly made, seconded and carried that the matter of proper certification of credentials and accurate seating of certified delegates and alternates be considered by the Board of Trustees and appropriate mechanisms developed at an early date.

## Resolutions

#### Resolution No. 72-1

Subject: INDIANA MEDICAL  
HISTORICAL  
FOUNDATION

HOUSE ACTION: Adopted as amended.

WHEREAS, at the turn of the century, Dr. Frank Wynn, then chairman of the Pathology Committee of the Indiana State Medical Association, suggested that the Association assume responsibility for the medical heritage and artifacts of the State of Indiana, and

WHEREAS, the Indiana Medical Historical Foundation now has been organized and incorporated as a not-for-profit, tax-exempt entity to achieve that end, and

WHEREAS, the Foundation already has functioned to preserve the old pathology building on the grounds of Central State Hospital, in Indianapolis, and

WHEREAS, the building now is recognized and listed on the National Register of Historical Places by the United States Department of the Interior; and

WHEREAS, the Foundation already has collected numerous artifacts, paintings and photographs relating to the history of medicine in Indiana;

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association encourage the efforts of the Indiana Medical Historical Foundation and urge the membership of ISMA to support this effort.

#### Resolution No. 72-2

Subject: LEGISLATION TO  
DEFINE THE WORD  
"PHYSICIAN"

##### HOUSE ACTION: Adopted.

WHEREAS, Indiana courts have construed the word "physician" to include a person engaged in the practice of chiropractic; and

WHEREAS, the term "physician" is ordinarily understood by laymen to signify persons who are graduates of schools of medicine or schools of osteopathy; and

WHEREAS, the application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

WHEREAS, this is confusing to the public, and therefore not conducive to the maintenance of a consistent standard of health care;

NOW, THEREFORE, BE IT RE-



SOLVED that the Indiana State Medical Association prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine or Doctor of Osteopathy.

### Resolution No. 72-3

Subject: SUBSTITUTING TB  
SKIN TESTS IN  
LIEU OF CHEST  
X-RAYS

**HOUSE ACTION:** Adopted as amended.

WHEREAS, those people in sensitive occupations and positions where early detection of tuberculosis is of the essence are required to have chest x-rays; and

WHEREAS, the present feeling of many in the medical community is that skin testing affords a better method for detecting individuals to be considered for medical therapy; and

WHEREAS, the opinion prevails in many areas that the chest x-ray as far as the tuberculous disease process be reserved for those individuals known to be positive reactors to the Mantoux skin test;

NOW, THEREFORE, BE IT RESOLVED the Indiana State Medical Association recommend to individual physicians and to appropriate legislative units that all those persons who in the past have been required to have an annual chest x-ray shall now receive appropriate skin testing with chest x-ray considered for positive reactors to the skin test.

### Resolution No. 72-4

Subject: FISCAL NOTE  
REQUIRED

**HOUSE ACTION:** Adopted as amended.

BE IT RESOLVED that Chapter IV, Sec. 5 of the Bylaws be amended by adding after the word "delegate" and the word "shall" the following: "shall be accompanied by a fiscal note and" and by adding a new sentence at the end of Sec. 5 to read as follows: "No proposal calling for appropriations shall be considered if not accompanied by a fiscal note."

As amended, Chapter IV, Sec. 5 would then read: Sec. 5. Proposals calling for

appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation, and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

### Resolution No. 72-5

Subject: SAMA  
REPRESENTATION  
IN THE HOUSE

**HOUSE ACTION:** Adopted.

BE IT RESOLVED that the Commission on Constitution and Bylaws prepare appropriate amendments to the Constitution and Bylaws to provide for a representative to be elected by the Indiana Chapter Student American Medical Association (SAMA) as a delegate to the state convention with the right to vote.

### Resolution No. 72-6

Subject: DISASSOCIATION  
INDIANA STATE  
MEDICAL  
ASSOCIATION  
AND MUTUAL  
MEDICAL  
INSURANCE, INC.  
(BLUE SHIELD)

**HOUSE ACTION:** Not adopted.

WHEREAS, Blue Shield has tried to enforce their attitudes and beliefs on the medical profession by their so-called "usual, customary and reasonable" fee schedules; and

WHEREAS, they state these fees are allegedly determined by fee profiles which they refuse to divulge to the physician or the county medical society; and

WHEREAS, our patient's hospital coverage is limited under criteria interpreted by their agent and/or consultant; and

WHEREAS, Blue Shield in at least three states have arbitrarily encouraged patients to take court action against their own physician at the expense of Blue Shield; and

WHEREAS, such legal expense along with increased clerical work, expenses of their professional relations would increase rather than decrease the cost of Medical Insurance; and

WHEREAS, such court action would serve to destroy any possible future relationship between the patient and his physician; and

WHEREAS, physician members of the Blue Shield Board, who are nominated for this office by the district medical societies and the Board of Trustees of ISMA, in effect bind physicians of this state through agreements made by them; and

WHEREAS, in 1970 the Ad Hoc Committee to study the relationships between physicians, county societies, the ISMA and Blue Shield recommended eleven points to be re-evaluated and corrected, stating that if satisfactory progress was not made in one year, the Board of Trustees consider separation of the Indiana State Medical Association and Blue Shield; and

WHEREAS, conditions have actually worsened rather than improved; and

WHEREAS, repeated petitions to the Board of Trustees have failed to provide such separation;

NOW, THEREFORE, BE IT RESOLVED that the Clark County Medical Society recommends that the House of Delegates of the Indiana State Medical Association hereby disassociate itself from Mutual Medical Insurance, Inc., (Blue Shield) and that it further withdraw its endorsement of this plan.

### Resolution No. 72-7

Subject: MEDICAL  
DEPARTMENT—  
BOARD OF  
CORRECTIONS

**HOUSE ACTION:** Adopted.

WHEREAS, the LaPorte County Medical Society has for the past 10 years recommended the establishment of a medical department within the Board of Corrections; and

WHEREAS, this recommendation has been accepted by the House of Delegates of the Indiana State Medical Association and forwarded to the state government each year for 10 years; and

WHEREAS, we see in national publications during the past few years more and more criticism and suggestions concerning all prisons in the United States; and

WHEREAS, the June meeting of the House of Delegates of the American



Medical Association recommended a study of the medical care in all the prisons in this country, both federal and state; and

WHEREAS, the Republican Candidate for governor in Indiana has publicly stated that our prisons should be given additional consideration;

The LaPorte County Medical Society again recommends that the medical care given the inmates of our correctional institutions be given serious consideration in any study or program aimed at improving these institutions.

Resolution No. 72-8

Subject: CHIROPRACTIC — DEFINITION

HOUSE ACTION: Adopted.

RESOLVED that the Indiana State Medical Association, through an appropriate Committee or Commission, in counsel with the Indiana State Board of Medical Registration and Examination, define the practice of chiropractic and the parameters of practice within the scope of chiropractic; and further be it

RESOLVED that this information then be made available to the members of the Indiana State Medical Association and the public at large.

Resolution No. 72-9

Subject: CHANGE NAME OF SECTION ON GENERAL PRACTICE TO SECTION OF FAMILY PHYSICIANS

HOUSE ACTION: Adopted.

WHEREAS, The American Academy of General Practice, meeting in Miami, Florida, October 2, 3, 4, 1971, officially changed the name of the organization to the American Academy of Family Physicians; and

WHEREAS, at that exact moment the Indiana Academy of General Practice became the Indiana Academy of Family Physicians; and

WHEREAS, the above name change more adequately describes the role and function of the present day generalist;

NOW, THEREFORE, BE IT RESOLVED, that the name of the above-

mentioned section be changed to the Section of Family Physicians.

Resolution No. 72-10

Subject: UTILIZATION OF PEER REVIEW MECHANISMS

HOUSE ACTION: Adopted as amended.

RESOLVED that, in contracts where benefits include physicians' fees, the ISMA make it unequivocally clear that management, labor and third party carriers shall consult with duly constituted representatives of organized medicine before determining "usual customary and reasonable" fees; and be it further

RESOLVED that wherever county peer review mechanisms exist, it is essential that third parties make use of them as a primary method of resolving differences prior to threats of litigation; and, in turn, that peer review mechanisms be utilized when dispute exists between patients, physicians and third parties referable to the quality of medical care rendered, professional fees or the medical necessity for hospitalization; and correspondingly that the medical profession continue to actively support the development of peer review mechanisms where they do not exist; and be it further

RESOLVED that the medical profession will not condone or tolerate action on the part of any third party that would encourage or promulgate litigation in the settlement of any such dispute; and be it further

RESOLVED that all medical insurance carriers and health plans be informed of this policy; and be it further

RESOLVED that the ISMA remind physicians that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered.

Resolution No. 72-11

Subject: COST OF HOSPITAL CARE

HOUSE ACTION: Adopted as amended.

WHEREAS the physicians of Indiana, as well as all other citizens of the state,

are concerned with the constantly escalating costs of health care; and

WHEREAS it has been statistically proven that hospital costs are the principal factor in the overall cost of health care; and

WHEREAS the attending physician is concerned with rising hospital costs and recognizes that he admits the patient to the hospital, orders the utilization of laboratory, x-ray and other facilities, and prescribes the medications and services necessary for the diagnosis and treatment of his patient which constitutes a part of this cost; and

WHEREAS the physician, in most instances, has no knowledge of the charges made to his patients by the hospital for various ancillary facilities and services it provides, or for the medications dispensed;

NOW, THEREFORE, BE IT RESOLVED that the ISMA instruct the president of ISMA to appoint an ad hoc committee to study hospital costs in Indiana and to bring the committee's recommendations to the Board of Trustees and subsequently to the next regular meeting of this House of Delegates in meaningful constructive form in order that this House can act in such a way to make meaningful recommendations to all concerned parties and to the Legislative Study Council of the Indiana Legislature if determined this would be pertinent in helping ISMA members participate in controlling rising hospital care costs in Indiana.

BE IT FURTHER RESOLVED, the House would also urge the Indiana Hospital Association and the private health insurance industry to cooperate with the physicians in the endeavor to assist us in slowing the rise in health care costs for the citizens of Indiana.

Resolution No. 72-12

Subject: BROWN COUNTY MEDICAL MUSEUM

HOUSE ACTION: Adopted.

WHEREAS the Brown County Medical Society was formed October 23, 1879, with constitution and bylaws recorded in the county courthouse; and

WHEREAS said Society became inactive and in 1946 associated with Bartholomew County Medical Society and is



now known as the Bartholomew-Brown County Medical Society; and

WHEREAS there exists a movement to establish a County Doctors' Museum in Nashville, Indiana, to perpetuate the memory of the country doctor;

THEREFORE BE IT RESOLVED, that the Indiana State Medical Association encourage and compliment the physicians residing in Brown County in their efforts to establish and perpetuate this project; and

BE IT FURTHER RESOLVED that physicians having medical historical items dating from the Civil War to the late 1880s be encouraged to make them available to enhance this museum.

### Resolution No. 72-13

Subject: HONORARY MEMBERSHIP. JOHN B. TWYMAN, EXECUTIVE DIRECTOR, LAKE COUNTY MEDICAL SOCIETY

#### HOUSE ACTION: Adopted.

WHEREAS John B. Twyman has served with distinction as the Executive Director of the Lake County Medical Society for 25 years; and

WHEREAS he has earned the respect and admiration of all the members of the Lake County Medical Society and of other physicians and Executive Directors/or Secretaries of other Societies throughout the State of Indiana, and

WHEREAS the Lake County Medical Society, has by due process, elected him an Honorary member of the Lake County Medical Society,

NOW, THEREFORE, BE IT RESOLVED that this House, in accordance with Article IV, Sec. 6 of the Constitution of Indiana State Medical Association, unanimously elects John B. Twyman an honorary member of Indiana State Medical Association because of the highly meritorious service he has rendered to the profession of medicine in Indiana.

### Resolution No. 72-14

Subject: T.B. TESTING — SCHOOL CHILDREN

#### HOUSE ACTION: Adopted as amended.

WHEREAS, in compliance with P. L. 322, approved April 8, 1971, requiring tuberculosis skin testing of all children entering the school system, the Indiana State Board of Health promulgated Regulation HT 6 stating that "any intradermal tuberculin test selected by the physician is acceptable"; and

WHEREAS the tine test and Mono Vac have been found most acceptable, efficient and economical for screening large numbers of children; and

WHEREAS the use of the Mantoux test in screening large numbers is more difficult to administer, emotionally disruptive and potentially less accurate when administered under mass screening measures; and

WHEREAS the Indiana State Board of Health changed regulation HT 6 to HT 6R, effective March 1972, requiring that the Mantoux be the only acceptable test to comply with the law;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association recommend that the Indiana State Board of Health continue to accept the intradermal test selected by the physician in order to comply with the law until newly available tine test (skin test) materials are available commercially to Indiana physicians.

### Resolution No. 72-15

Subject: MEDICAL LIABILITY LEGISLATION

#### HOUSE ACTION: Adopted as amended.

WHEREAS medical liability has been a complicating problem for patient and physician alike; and

WHEREAS any deterrent to the filing of so-called "nuisance" suits would be beneficial to patients, M.D.s and attorneys; and

WHEREAS, the California legislature has had introduced and passed two major pieces of legislation to deter and limit the institution of such suits;

NOW, THEREFORE, BE IT RESOLVED that ISMA go on record as endorsing programs which require the plaintiff to post bond in medical liability suits and provisions for forfeiture; and

BE IT FURTHER RESOLVED that ISMA sponsor legislation based on such a law in the next general session of Indiana's legislature to accomplish this same end.

### Resolution No. 72-16

Subject: NOMINATIONS OF ISMA OFFICERS AND AMA DELEGATES

#### HOUSE ACTION: Adopted.

WHEREAS, much time is spent by this House listening to nominating speeches and seconding speeches; and

WHEREAS, this honorable but time consuming practice takes time that might be better spent on issues facing our profession;

NOW, THEREFORE, BE IT RESOLVED that the chair be advised in advance of all nominations to be made; and

BE IT FURTHER RESOLVED that (1) all nominating speeches be limited to five minutes, (2) in uncontested nominations two seconding speeches of one minute each be allowed, the second person to move to close the nominations and a ballot be cast for his election, (3) in contested nominations not more than two seconding speeches of one minute each be allowed per candidate. The seconds shall be selected by the candidate.

### Resolution No. 72-17

Subject: CONFERRING HONORARY MEMBERSHIP ON PAUL S. RHOADS, M.D.

#### HOUSE ACTION: Adopted.

WHEREAS Doctor Rhoads is a physician who has served his profession with distinction throughout his years as a physician and is currently practicing in Richmond, Indiana; and

WHEREAS, Doctor Rhoads has served as professor of medicine in Northwestern University School of Medicine; chairman of the Board of Governors of the Institute of Medicine in Chicago; and as chief administrator of the Archives of Internal Medicine; not to mention numerous other accomplishments during his career;

THEREFORE, BE IT RESOLVED



that this House of Delegates confer honorary membership on Dr. Paul S. Rhoads of Richmond, Indiana.

## Resolution No. 72-18

Subject: MEDICARE AND  
MEDICAID CLAIMS

### HOUSE ACTION: Not adopted.

WHEREAS doctors throughout the State of Indiana are constantly finding difficulties with their payments from Medicare and Medicaid; and

WHEREAS individual physicians going to Blue Shield or Blue Cross concerning complaints seems to be of little avail and of very little result; and

WHEREAS the government is constantly increasing these programs, such as from 54,000 in 1970 to over 200,000 in 1972 on Medicaid alone; and

WHEREAS, it is felt that each doctor would be willing to pay whatever the cost might be decided per claim that he requested for him, thus making this a fiscal responsible program;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association use an employee either part time or full time to adjudicate claims between members of the Association and Blue Shield concerning Medicaid and Medicare claims.

BE IT FURTHER RESOLVED that the Indiana State Medical Association staff figure the cost per claim of such an investigation and pass this cost to the individual requesting the adjudication.

## Resolution No. 72-19A

Subject: DECLARATION OF  
NON-PARTICIPATION  
POLICY

HOUSE ACTION: Adopted as amended. Portion dealing with funds referred to Board of Trustees for further study and possible action and report back to the House of Delegates in 1973.

WHEREAS the free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor; and

WHEREAS government intervention

between the practicing physician and the patient historically removes responsibility from both parties and leads to decreasing quality of medical care; and

WHEREAS the current proposals for federal regimentation of medical care which are before the Congress (Senate Bill 3 and H. R. 7741) will result in total control of all patients and all doctors, with no free choice alternative; and

WHEREAS the members of the Indiana State Medical Association wish to continue to provide medical services in the most efficient manner, retaining mutual respect and responsibility between patient and physician; and

WHEREAS no plan of socialized medicine or other form of government sponsored health care plan can function without cooperation and participation of the majority of the physicians of the involved community;

NOW, THEREFORE, BE IT RESOLVED that ISMA notify members of Congress and the public that we will continue to actively work for enactment of legislation, supporting fee-for-service, the traditional patient-doctor relationship, state licensure of medical practitioners, voluntary relocation of physicians, the right of privileged communication between the patient and his doctor, and the institution of voluntary review requirements;

BE IT FURTHER RESOLVED that a fund be set aside from a \$3.00 per member increase in dues to provide adequate legal counsel for class action suits to stop implementation of economic regulations which apply in a discriminatory fashion to physicians, and would also provide for legal defense for all members of Indiana State Medical Association who come under criminal prosecution for violation of any of these regulations.

## Resolution No. 72-20

Subject: CREATION OF  
OFFICES OF  
SPEAKER AND  
VICE-SPEAKER

HOUSE ACTION: Adopted as amended.

WHEREAS establishment of the offices of speaker and vice-speaker of the House of Delegates of the Indiana State Medical Association has been suggested for many years, but without action; and

WHEREAS many state medical associations have seen the need for such offices and have created them, to the advantage of those organizations; and

WHEREAS conducting meetings of the House of Delegates in addition to his many other duties and responsibilities put an unconscionable demand upon the time and energies of the president of the Indiana State Medical Association;

THEREFORE, BE IT RESOLVED that the Commission on Constitution and Bylaws of the Indiana State Medical Association be mandated to prepare an appropriate amendment to provide for a Speaker and a vice-speaker of the House of Delegates, to be elected annually from the membership of the House, and that the speaker be a voting member of the Executive Committee and the Board of Trustees; and

BE IT FURTHER RESOLVED, that presentation of this resolution and its adoption be considered the first review of the proposed amendment by the House of Delegates so that the actual amendment can be voted upon in the 1973 meeting of the House.

## Presidential Resolution

HOUSE ACTION: Adopted by acclamation.

WHEREAS organized medicine is faced today with pressures for change in the delivery of health care; and

WHEREAS added to these pressures is the ever growing volume of medical information and knowledge which, while it changes, becomes obsolete in tune with the rapid pace of the 20th Century; and

WHEREAS these changes and pressures bring to bear on organized medicine and the individual practitioner a weight of responsibility and a demand for excellence which grows more intense by the day; and

WHEREAS, to meet the challenges and pressure of this age, leadership must be found within the profession to represent the historic ideals of medicine and capable of meeting the challenges of current times; and

WHEREAS Dr. Peter R. Petrich, as president of the Indiana State Medical Association, has with vigor, dedication and devotion to his fellow practitioners met these strenuous qualifications as president, and performed his duties of office with skill and determination;



NOW, THEREFORE, BE IT RESOLVED that this House of Delegates extend to him their deepest thanks for his leadership and direction during 1971-1972.

### Resolution of Appreciation

**HOUSE ACTION:** Adopted by acclamation. Resolution to the Indiana Convention-Exposition Center, Hilton Hotel and Miss Elsie Reid.

WHEREAS the success of any Convention is contingent in large part on the facilities available and the management of those facilities; and

WHEREAS the Convention-Exposition Center and the Hilton Hotel in Indiana-

polis have contributed to the success of the 123rd Annual Convention of the Indiana State Medical Association; and

WHEREAS the dedicated staff of the Indiana State Medical Association, as always, additionally provided their expertise and dedicated labors to ensuring a smooth-functioning Convention; and

WHEREAS Miss Elsie Reid completes her fortieth year of service to the Indiana State Medical Association in many capacities and has watched the organization grow and prosper;

NOW, THEREFORE, BE IT RESOLVED that the House of Delegates extend to Miss Reid and others on the staff of ISMA its warmest gratitude for a job well done, and also extend their

thanks to the Convention-Exposition Center and the Hilton Hotel.

### Place of Future Annual Conventions

1973—Indianapolis—October 6-11

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1976—Indianapolis—October 9-14

1977—Indianapolis

### Adjournment

The House of Delegates adjourned, sine die, at 11:25 a.m., Wednesday, October 18, 1972.



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COCOA BEACH, FLA. Nearest beach, Disneyworld. Charming cypress beach house, ocean front, wide, safe beach, 3 bdrms, 2 baths, family rm, and living rm., 2 TV's, completely carpeted and panelled. Air and heat. All appliances, linens furnished. Sleeps 10. Available Sept. and following months. \$250/wk. Ray D. Foster, M.D., 1944 N. Capitol Ave., Indianapolis, Ind. 46202.

FAMILY PHYSICIAN or Internist wanted to associate in busy practice with surgeon to take over load left by recently deceased physician. If salary desired, will negotiate or help him to start his own practice. Town of 25,000, very modern hospital facilities and office. Reply Box 383.

WANTED: TWO (2) FAMILY PHYSICIANS—to join group of three (3) well established family physicians who recently moved into their ultra modern clinic building next to the new 431 bed hospital in Richmond, Indiana. Reply Box 382, THE JOURNAL, ISMA, 3935 N. Meridian St., Indianapolis 46208.

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Continued

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GENERAL PRACTICE—Three man medical corporation wants fourth man with initiative to share unlimited general practice located in Northeast Indiana in the middle of 100 lakes. One hour to either South Bend or Fort Wayne. Two hours to Chicago or Detroit. Share interest in Turbo-Aztec. Share unlimited medical challenge with unlimited income. Reap tax rewards of medical corporation with more than ample income left over. In this group you are limited only by your own initiative. Four weeks vacation plus two weeks post graduate training paid by the corporation yearly. Other corporation benefits too numerous to mention. Family Physicians, Inc., P. O. Box 217, Howe, Indiana, 46746, 219-562-2101.

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# The JOURNAL

of the

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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